WITHIN CORPORATE LIMITS

STATE OF MARYLAND—CERTIFICATE OF DEATH

04500

1. PLACE OF DEATH

County Allegany — Registration Dist. No. 4

Village or City Cumberland — No. Haystack Sanatorium — Ward 1-5

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Edward R Albright — If U. S. Veteran, specify WAR ...

(a) Residence: No. Valley St. St., ... Ward. ...

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of Mildred Kease

6. DATE OF BIRTH (month, day, and year) Nov 28 1893

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	5	8	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Laborer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. N. C. A.

10. Date deceased last worked at this occupation (month and year) ? — 11. Total time (years) spent in this occupation ?

12. BIRTHPLACE (city or town) (State or country) Jonesfield W. Va.

FATHER

13. NAME Albright Albright

14. BIRTHPLACE (city or town) (State or country) W. Va.

MOTHER

15. MAIDEN NAME Sally Smith

16. BIRTHPLACE (city or town) (State or country) W. Va.

17. INFORMANT Albert Albright (Address) Cumberland.

18. BURIAL, CREMATION, OR REMOVAL Place Bellevue Cem. Date May 8, 1939

19. UNDERTAKER Louis Stein Sons (Address) Cumberland

20. FILED 5/8/, 1939 J. O. Franklin, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH 5 (Month) — 6 (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 4-16-1939 to 5-6-39

I last saw h... alive on 5-4-39; death is said to have occurred on the date stated above, at 8:45 a

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Pulmonary Tuberculosis	?

Other **Contributory Causes** of Importance:

Name of operation ... Date of ...

What test confirmed diagnosis? Phy. Ex. Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of Injury ..., 19...

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify ...

(Signed) Wm. J. Williamson

(Address) Cumberland, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

RECEIVED JUN 6 1929 BUREAU V. S.

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (111-6) CNB Reg. Dist. No. 4

CERTIFICATE OF DEATH

04501

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Allegany Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State W. Va (b) County Mineral
(c) City or town Fort Ashby (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Allie Dennison Alkire

3 (b) If veteran, name war | 3 (c) Social Security No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Soloman Alkire

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5 1865.

8. AGE: Years 73 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Fort Ashby (Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER
12. Name Robert Dennison
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Twigg
15. Birthplace Twiggtown Md.

16 (a) Informant Melvin Alpine
(b) Address Springfield W. Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 30, 1939 (month) (day) (year)
(c) Cemetery or crematory Fort Ashby
Location Fort Ashby W. Va

18 (a) Funeral director Jacob Hafer
(b) Address Cumberland, Md.

19 (a) May 29, 1939 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

Zimmerman

MEDICAL CERTIFICATION

20. Date of death 5/28/39 19 , at 12:25 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/13/39 19 , to 5/28/39 19 , and that I last saw him alive on 5/28 1939

Immediate cause of death	Duration
Pulmonary infarct	5/21/39
Due to	
Due to	
Other conditions Toxemia	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D. or other

Address 105 S. Centre St. Cumberland, Md. Date signed 5/29/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

WITHIN CORPORATE LIMITS

Bureau of Vital Statistics, Baltimore (73-d)

Reg. Dist. No. 9

045 62

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany.

(b) City or town Frostburg, Md.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in this community (yrs., mos., or days) 36 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town Frostburg.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 135 E. Main St.
(If rural give location)

(e) If foreign born, how long in U. S. A.? —— years

3 (a) **FULL NAME** Robert Anderson.

3 (b) If veteran, name war —

3 (c) Social Security No. 214-01-0155

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed.

6 (b) Name of husband or wife Mabel Keifer Anderson, Dec.

6. (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1902

8. AGE: Years	Months	Days	If less than one day
36	8	7	____ hr. ____ min.

9. Birthplace Lonaconing, Md.
(Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business W.P.A.

FATHER
12. Name James Anderson.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Annie Price Anderson
15. Birthplace Maryland.

16 (a) Informant Margaret Stewart.
(b) Address Washington St., Frostburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21, 1939 (month) (day) (year)

(c) Cemetery or crematory Allegany Cemetery.
Location Frostburg, Maryland.

18 (a) Funeral director Jacob Nafle.
(b) Address 23-25 E. Union St., Frostburg, Md.

19 (a) 5-21-39 (Date rec'd by registrar) (b) Mrs. A. R. Walter Registrar

MEDICAL CERTIFICATION

20. Date of death May 19 1939, at 2:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from —— 19—, to —— 19—, and that I last saw him alive on —— 19—.

Immediate cause of death	Duration
Myocardial Insufficiency	2 hours
Due to —	
Due to —	
Other conditions Not known	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence —

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury —

23. Signature W. E. Gattens M.D.
M.D. or other

Address Frostburg, Md. Date signed May 9, 1939

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (9HF)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

04503

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH.

(a) County Allegany

(b) City or town Cumberland, Md.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hr.

(e) Length of stay in this community (yrs., mos., or days) _____

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Cumberland
(If outside city or town limits, write RURAL and give town)

(d) Street No. 410 Park St.
(If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** Russell Leroy Atwell

3 (b) If veteran, name war _____

3 (c) Social Security No. 205-05-7730

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Hickman

6. (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Dec 26, 1901

8. AGE: Years	Months	Days	If less than one day
37	5	5	_____ hr. _____ min.

9. Birthplace Frostburg, Allegany, Md.
(Town, county, and state)

10. Usual occupation Car Inspector

11. Industry or business B & O. Railroad

FATHER 12. Name Chas Wm. Atwell

FATHER 13. Birthplace Leesburg, Va.

MOTHER 14. Maiden Name Lucy Belle Jackson

MOTHER 15. Birthplace Leesburg, Va.

16 (a) Informant Mrs Va. Lee Rice

(b) Address 104 Decatur St. Cumb. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4 1939 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Cumberland, Md.

18 (a) Funeral director Jacob Hafer

(b) Address Cumberland Md.

19 (a) 5/3/39 (Date rec'd by registrar) (b) J. I. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 1 1939, at _____ M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1939, to May 1 1939, and that I last saw him alive on _____ 19____.

Immediate cause of death	Duration
(a) Coronary Thrombosis	Not known
Due to (b) Not known	
Due to (c)	
Due to (d)	
Other conditions None Determined	

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy Coronary occlusion with thrombus of coronary vessels

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ (Specify type of place) While at work? _____

(e) Means of injury _____ (Coroner)

23. Signature H. K. Deming M.D.
M.D. or other

Address 67 N Centre St Date signed 5-2-39

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WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (947)

Reg. Dist. No. 4

04504

CERTIFICATE OF DEATH

1. PLACE OF DEATH

(a) County Allegany

(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 413 Pulaski St.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 44 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(d) Street No. 413 Pulaski St. (If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Justin Barkman

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Jessie Hinkle

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29, 1880

8. AGE: Years 58 Months 7 Days 22 If less than one day ___ hr. ___ min.

9. Birthplace Flintstone, Md. (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Post office

FATHER 12. Name Benjamin Barkman

13. Birthplace Pa.

MOTHER 14. Maiden Name Dorothy Herbst

15. Birthplace Md.

16 (a) Informant Mrs Jessie Barkman

(b) Address 413 Pulaski

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-39 (month) (day) (year)

(c) Cemetery or crematory Rose Hill Cem

Location Cumberland

18 (a) Funeral director Louis Stern Inc

(b) Address Cumberland

19 (a) 5/23/39 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death 5-21-39 19__, at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 39 19__, to 5-21 39 19__, and that I last saw him alive on 5-15 39 19__.

Immediate cause of death Coronary Thrombosis — Duration Instantly

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. Alfred Van Ames M. D. or other

Address Cumberland, Md Date signed 5-22-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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JUN 8 1939
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MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (947) Reg. Dist. No. 8

CERTIFICATE OF DEATH

04505

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Gilmore
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 30 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County Allegany
(c) City or town Gilmore
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Mary Rozina Green Beaman

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Andrew Beaman

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 25, 1874

8. AGE: Years 64 | Months 7 | Days 13 | If less than one day — hr. — min.

9. Birthplace Lonaconing
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER
12. Name Jefferson Green
13. Birthplace Lonaconing, Md.

MOTHER
14. Maiden Name Alice Metz
15. Birthplace Lonaconing Md.

16 (a) Informant Mrs. Celestine Beaman
(b) Address Gilmore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14 1939 (month) (day) (year)
(c) Cemetery or crematory Green's Cemetery
Location Garrett County Md.

18 (a) Funeral director Mr. Eichhorn
(b) Address Lonaconing, Md

19 (a) May 11-1939 (Date rec'd by registrar) (b) D. E. Doyle Registrar

MEDICAL CERTIFICATION

20. Date of death May 8 1939, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from — 19—, to — 19—, and that I last saw him alive on — 19—.

Immediate cause of death	Duration
Sudden death without previous illness	
Due to Coronary Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Harry M. Hodgson M.D.
(M. D. or other)
Address Lonaconing, Md Date signed 5/9/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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JUN 6 1989
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MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 9

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

(186a)

04506

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 55 W. Main St.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 82 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Frostburg, Md (If outside city or town limits, write RURAL and give town)

(d) Street No. 55 W. Main St. (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Emma Elizabeth Jarrett Betz.

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Daniel Jacob Betz

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 17, 1856

8. AGE: Years 82 Months 11 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Frostburg Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Jacob Jarrett

13. Birthplace Philadelphia, Pa.

MOTHER

14. Maiden Name Sarah Beeman

15. Birthplace Frostburg, Md.

16 (a) Informant Nellie Betz

(b) Address Frostburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29, 1939 (month) (day) (year)

(c) Cemetery or crematory Allegany

Location Frostburg Md.

18 (a) Funeral director Jacob Hafer

(b) Address Frostburg Md.

19 (a) 5-29-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death May 26 1939 at 11 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1938, to 5-26 1939 and that I last saw him alive on 5-26-1939.

Immediate cause of death Acute cardiac dilatation

Due to Chronic endocarditis

Due to

Other conditions Fracture of right arm & right pelvis (Include pregnancy within 3 months of death)

Major findings: due to an accidental fall. cw.g.c.

Of operations

Of autopsy

Duration: A few moments. For several years

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accidental fall.

(b) Date of occurrence December 20th, 1938.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home - (Specify type of place) While at work?

(e) Means of injury

23. Signature J. C. Cohen M. D. or other

Address Frostburg Md Date signed 5-27-39

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUN 6 1939
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

04507

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH (159)

County Allegany — Registration Dist. No. 1

Village or City Cedtown — No. — St., — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S. If of foreign birth? — yrs. — mos. — ds.

2. FULL NAME No Name Bishop — If U. S. Veteran specify WAR —

(a) Residence: No. — St., — Ward. —

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	W	Infant

5e. If married, widowed, or divorced — HUSBAND of (or) WIFE of — Infant.

6. DATE OF BIRTH (month, day, and year) May 19, 1939

7. AGE	Years	Months	Days	If LESS than 1 day, — hrs. or 20 min.
	—	—	—	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. —

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date last worked at this occupation (month and year) — 11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) Cedtown (State or country)

FATHER

13. NAME Joseph F. Bishop

14. BIRTHPLACE (city or town) Md (State or country)

MOTHER

15. MAIDEN NAME Ellis Pinter

16. BIRTHPLACE (city or town) Pa (State or country)

17. INFORMANT Joseph F. Bishop (Address) Cedtown Md

18. BURIAL, CREMATION, OR REMOVAL Place Rose's Grove Cem. Date May 19, 1939

19. UNDERTAKER Joseph F. Bishop attendant (Address) R-1 Cedtown Md

20. FILED May 19, 1939 Mrs. P. A. Shaulett Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 19 (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from — 19— to — 19—

I last saw h— alive on Died May 19, 1939; daath is said to hava occurrad on tha date statad above, at 1:40 a. m.

The **PRINCIPAL CAUSE OF DEATH** and relatad causes of importance ware as follows:

	Date of onset
Premature birth	
5 Minutes.	
Least Known Cause	
Other **Contributory Causes** of Importance:	

Name of operation None — Date of —

What test confirmed diagnosis? History — Was there an autopsy? No.

23. If daath was due to external causas (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury —, 19—

Whara did injury occur? — (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE. —

Manner of Injury —

Neture of Injury —

24. Was disaase or injury in any way ralatad to occupation of daceased? —

If so, specify —

(Signad) W. H. Hammon M. D.

(Address) Penn Penn

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precisc statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (742) Reg. Dist. No. 8

CERTIFICATE OF DEATH

04508

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in this community (yrs., mos., or days) —

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County Allegany
(c) City or town Frostburg (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Elizabeth Bittinger
3 (b) If veteran, name war —
3 (c) Social Security No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife Jacob Bittinger
6. (c) If alive, give age 68 years
7. Birth date of deceased (mo., day, yr.) July 11, 1869
8. AGE: Years 69 Months 9 Days 20 If less than one day ____ hr. ____ min.
9. Birthplace Jennings Maryland (Town, county, and state)
10. Usual occupation Housework
11. Industry or business Home

FATHER
12. Name Jacob Hoover
13. Birthplace Jennings Maryland

MOTHER
14. Maiden Name Mary Bittinger
15. Birthplace Jennings Md

16 (a) Informant Raymond Bittinger
(b) Address Lonaconing Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3rd 1939 (month) (day) (year)
(c) Cemetery or crematory Laurel Hill
Location Allegany County, Md.

18 (a) Funeral director M. Eichhorn
(b) Address Lonaconing, Md.

19 (a) May 3-1939 (Date rec'd by registrar) (b) D. E. Offutt Registrar

MEDICAL CERTIFICATION

20. Date of death May 1st 1939, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from — 19— to — 19—, and that I last saw him alive on — 19—.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature J. Harry Jr. Hodgson M.D. (M. D. or other)
Address Lonaconing Md. Date signed 5/1/39

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WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (94L)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

04509

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Allegany Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in this community (yrs., mos., or days) 64

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Cumberland-La Vale (If outside city or town limits, write RURAL and give town)
(d) Street No. Cash Valley Rd. (If rural give location)
(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Ross H. Brant.

3 (b) If veteran, name war —

3 (c) Social Security No. 214-05-7860

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Zella Frantz

6. (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) March 19 1875

8. AGE: Years 64 | Months 2 | Days 2 | If less than one day: _____ hr. _____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Bank Messenger & Janitor

11. Industry or business Glass Factory

FATHER
12. Name Andrew Brant
13. Birthplace Md

MOTHER
14. Maiden Name Ellen Bell
15. Birthplace Penna

16 (a) Informant Ralph R. Brant
(b) Address Cumberland.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24-39 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Cumberland Md

18 (a) Funeral director U. L. Lamparesn
(b) Address Cumberland, Md.

19 (a) May 23 1939 (Date rec'd by registrar) (b) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 21 1939, at 7.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-21 1939, to 5-21 1939, and that I last saw him ~~alive~~ dead on 5-21 1939.

Immediate cause of death	Duration
Coronary thrombosis	3 minutes
Due to Sclerosis of the coronary arteries	(?)
Due to	
Other conditions Arteriosclerosis	(?)

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature H. V. Deming M.D. (Coroner) M. D. or other
Address 67 N. Center St Date signed 5-22-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

VS. A15

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WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (17)

Reg. Dist. No. 4

04510

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Allegany Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in this community (yrs., mos., or days) Life

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Garrett

(c) City or town Swanton Route 5 (If outside city or town limits, write RURAL and give town)

(d) Street No. _____ (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Pearl Edna Broadwater

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Yorman Broadwater

6. (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) March 22-1903

8. AGE: Years 36 Months 1 Days 26 If less than one day _____ hr. _____ min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER

12. Name Frank Broadwater

13. Birthplace Md

MOTHER

14. Maiden Name Stella Henline

15. Birthplace W Va

16 (a) Informant Yorman Broadwater

(b) Address Swanton Route 5

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-39 (month) (day) (year)

(c) Cemetery or crematory _____

Location New Germany Md

18 (a) Funeral director Wm Winterberg

(b) Address Grantsville, Md

19 (a) 5/20/39 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 18 1939, at 11 50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1939, to May 18 1939, and that I last saw him alive on May 18 1939

Immediate cause of death: Encephalitis Lethargica — Duration: 3 wks

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ (Specify type of place) While at work? _____

(e) Means of injury _____

23. Signature P. C. Bowen M.D. (M. D. or other)

Address Cumberland, Md. Date signed 5-19-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

(181)

Reg. Dist. No. 4

04511

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Allegany Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in this community (yrs., mos., or days) 40

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 Fairview Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Lillian Elizabeth Castle

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband ~~or wife~~ Harry E. Castle

6. (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) July 15 1898

8. AGE: Years 40 Months 10 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home.

FATHER
12. Name John Foster
13. Birthplace Germany.

MOTHER
14. Maiden Name Catherine Wiegand
15. Birthplace Germany.

16 (a) Informant Harry E. Castle
(b) Address Cumberland.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27 '39 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Greenmont Cem.
Location Cumberland

18 (a) Funeral director Louis Stein Inc.
(b) Address Cumberland

19 (a) May 26, 1939 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 24 1939, at 9:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1939, to May 24 1939, and that I last saw him alive on May 24 1937.

Immediate cause of death	Duration
Extensive 2nd & 3rd degree Burns	
Due to	
Ignition by Hot Water Heater	13 hours
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5/24/39
(c) Where did injury occur? Cumberland (City or town), Allegany (County), Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Burns

23. Signature Samuel Jacobson M.D. M. D. ~~or other~~
Address 119 Bedford St. Date signed 5/25/39

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

WITHIN CORPORATE LIMITS

STATE OF MARYLAND—CERTIFICATE OF DEATH

04512

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Allegany — Registration Dist. No. 4

Village or City Cumberland — No. Allegany Hospital — St., 4-1 — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Baby Boy Chambers — If U. S. Veteran, specify WAR ____

(a) Residence: No. ____ St., ____ Ward. ____

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Single

5e. If married, widowed, or divorced: HUSBAND of (or) WIFE of ____

6. DATE OF BIRTH (month, day, and year) 5-14-39

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. ____

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. ____

10. Date deceased last worked at this occupation (month and year) ____ — 11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) Cumberland (State or country) Md

FATHER

13. NAME George Kenneth Chambers

14. BIRTHPLACE (city or town) Crafton, Pa. (State or country)

MOTHER

15. MAIDEN NAME Marie Carabelle Kornhoff

16. BIRTHPLACE (city or town) Cumberland (State or country) Md.

17. INFORMANT Mrs. Marie Chambers

(Address) 125 Elder St. Cumberland, Md.

18. BURIAL, CREMATION OR REMOVAL

Place Chamber Cem. Date May 17, 1939

Williams Ed.

19. UNDERTAKER Geo. K. Chambers

(Address) 125 Elder St., City

20. FILED 5/17/, 1939 J. P. Franklin, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH 5 (Month) 14 (Dey), 1939 (Yeer)

22. I HEREBY CERTIFY, That I attended deceased from 4-21-, 1939, to 5-12, 1939

I last saw him alive on May 12, 1939; death is said to have occurred on the date stated above, at 6:30 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Appendectomy on mother	
Premature Labor Fetus	
Stillborn	

Other Contributory Causes of importance:

Cirrhosis Liver

Peritonitis

Neme of operetion ____ Date of ____

Whet test confirmed diegnosis? ____ Was there en autopsy? ____

23. If deeth wes due to externel causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Dete of injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Menner of injury ____

Nature of Injury ____

24. Was diseese or injury in any wey releted to occupetion of deceased? ____

If so, specify ____

(Signed) E. Allan Edmunds M. D.

(Address) 421 Seymour Cumberland

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 9

04513

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Frostburg
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Miners Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in this community (yrs., mos., or days) —

2. HOME (USUAL RESIDENCE) OF DECEASED: ✓
(a) State — (b) County ✓
(c) City or town ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. ✓
(If rural give location)
(e) If foreign born, how long in U. S. A.? ✓ years

3 (a) **FULL NAME** Stillborn Coleman

3 (b) If veteran, name war —
3 (c) Social Security No. —

4. Sex ✓
5. Color or race W
6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —
6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) —

8. **AGE:** Years — Months — Days — If less than one day ___ hr. ___ min.

9. Birthplace Frostburg, Md
(Town, county, and state)

10. Usual occupation
11. Industry or business —

FATHER
12. Name Manuel Coleman
13. Birthplace Midlothian Md

MOTHER
14. Maiden Name Cleo V. Rizer
15. Birthplace Eckhart Md

16 (a) Informant Mrs Manuel Coleman
(b) Address Zihlman Md

17 (a) ___ (Burial, cremation, or removal) (b) Date thereof ___ (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) 5-28-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death May 26 1939, at 10-30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Not at all 19__, to 19__, and that I last saw him alive on 19__.

Immediate cause of death Stillborn

Due to ✓

Due to ✓

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Cobey M.D.
M. D. or other

Address Frostburg Md Date signed May 27-39

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93C) Reg. Dist. No. 6

CERTIFICATE OF DEATH

04514

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Westernport, Md
WITHIN CITY LIMITS (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
The Reeves Clinic 121 Main St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Westernport
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 Vine Street
(If rural give location)
(e) If foreign born, how long in U. S. A.? ✓ years

3 (a) **FULL NAME** Otha Coleman

3 (b) If veteran, name war ✓
3 (c) Social Security No. ✓

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Catherine M. Dade
6. (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1858

8. AGE: Years 81 | Months 7 | Days 17 | If less than one day ____hr. ____min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Miner
11. Industry or business Coal Mine

FATHER
12. Name Manuel Coleman
13. Birthplace Unknown

MOTHER
14. Maiden Name Elizabeth Jenkins
15. Birthplace Unknown

16 (a) Informant Mrs. Alef Tennent
(b) Address Dunbarwood, Ohio

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24, 39 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Westernport, Md

18 (a) Funeral director M. Eichhorn
(b) Address Lonaconing, Md

19 (a) May 22, 1939 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. Date of death May 21 1939, at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1939, to May 21 1939, and that I last saw him alive on May 21 1939.

Immediate cause of death	Duration
Bronchopneumonia (Terminal)	2 days
Due to Chr. Prostatitis	4 mos.
Due to	
Other conditions Arteriosclerosis Chr. Myocarditis	4 yrs.

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman Reeves M.D. M. D. or other
Address Westernport, Md Date signed 5-22-39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 3 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (13) Reg. Dist. No. 4

CERTIFICATE OF DEATH

04515

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 114 N. Fred St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 8 mos

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 N. First St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** Wm. Franklin Cook

3 (b) If veteran, name war _____ 3 (c) Social Security No. _____

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna Stricker

6. (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Sept 4 1856

8. AGE: Years	Months	Days	If less than one day
82	8	5	_____ hr. _____ min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation Prisoner

11. Industry or business U. S. R. R.

FATHER
12. Name Wm S. Cook
13. Birthplace Md.

MOTHER
14. Maiden Name Mary A. Rhodes
15. Birthplace Md.

16 (a) Informant Wm. L. Cook
(b) Address Cumberland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10 (month) (day) '39 (year)
(c) Cemetery or crematory Hillcrest Mem.
Location Cumberland

18 (a) Funeral director Gonio Stein Inc.
(b) Address Cumberland

19 (a) 5/10/39 (Date rec'd by registrar) (b) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. **Date of death** May 7 1939, at 3.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1939, to May 7 1939, and that I last saw him alive on May 7 1939.

Immediate cause of death	Duration
Uremia	2 hrs
Due to Chronic Interstitial Nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence No
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No (Specify type of place) While at work?
(e) Means of injury

23. **Signature** W. K. B. Owens M. D. or other
Address 133 Va Ave Date signed May 8 1939

VS. A15

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY WITH UNFADING INK.

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (59)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

04516

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 711 Baltimore Ave

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 35 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(d) Street No. 711 Baltimore Ave (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Alice Almeda Core.

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife George W. Core

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 16, 1880

8. AGE: Years 59 Months 0 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Glencoe, Pa. (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Henry Martz

13. Birthplace Unknown

MOTHER 14. Maiden Name Mary Fair

15. Birthplace Unknown

16 (a) Informant Ira L. Smith

(b) Address 711 Baltimore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14 1939 (month) (day) (year)

(c) Cemetery or crematory Kammer Cemetery

Location Fairhope, Pa.

18 (a) Funeral director Jacob Hafer

(b) Address Cumberland, Md.

19 (a) 5/13/39 (Date rec'd by registrar) (b) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 11 1939, at 7:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1939, to May 11 1939, and that I last saw him alive on May 11 1939.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Hypertension	6 yrs
Due to Chr. Nephritis	6 yrs
Other conditions Myocarditis with Fibrillation & Diabetes mellitus (Include pregnancy within 3 months of death)	

Major findings:

Of operations ✓

Of autopsy ✓

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature L. J. Larrick M. D. or other

Address Cumberland Md Date signed 5/13-39

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 2

04517

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) ~~City or town~~ Rural Merley's Branch Md
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Town Creek Rd.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Rural Merley's Branch Md
(If outside city or town limits, write RURAL and give town)

(d) Street No. Old Town Dist.
(If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Miss Hazel Crabtree

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife —

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct 1 1927

8. AGE: Years 11 Months 7 Days 18 If less than one day ____ hr. ____ min.

9. Birthplace Merley's Branch Md
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER
12. Name Denton W. Crabtree
13. Birthplace Maple Run Md Old Town Dist. Md

MOTHER
14. Maiden Name Viola Twigg
15. Birthplace Polish Mt. Flintstone Dist Md

16 (a) Informant Ed. Twigg
(b) Address Siebert Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20 39 (month) (day) (year)
(c) Cemetery or crematory Bible Ave.
Location Gilpintown Md.

18 (a) Funeral director Louis Stein Inc.
(b) Address Cumberland

19 (a) May 19 (Date rec'd by registrar) (b) D. Bennett Registrar

MEDICAL CERTIFICATION

20. Date of death May 18 1939, at 4:30 P M

21. I certify that death occurred on the date above stated; that I ~~attended~~ saw deceased from — 1939, to May 18 1939, and that I last saw ~~him alive~~ HER DEAD on May 18 1939.

Immediate cause of death	Duration
Septicemia	4 days
Bronchopneumonia	9 days
Due to Abscess of left lung about	7 days
Due to Influenza	13 days
Other conditions Treated by Christian Science Practitioner. (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert V Deming M.D. (Coroner) M. D. or other

Address 67 N Centre St Cumberland, Md Date signed 5-18/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 6 1939
BUREAU N. S.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-C) Reg. Dist. No. 9

04518

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg R. F. D.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Residence Hoffman Mines

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED: Hoffman Mines

(a) State Md (b) County Allegany

(c) City or town Frostburg R.F.D.
(If outside city or town limits, write RURAL and give town)

(d) Street No.
(If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** James E Croston

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Carry Croston

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug 4-1868

8. **AGE:** Years 70 Months 9 Days 16 If less than one day hr. min.

9. Birthplace Paw Paw Wiva
(Town, county and state)

10. Usual occupation stable boss

11. Industry or business coal mines

FATHER
12. Name John W. Croston
13. Birthplace U.S.

MOTHER
14. Maiden Name Mc Bride
15. Birthplace U.S.

16 (a) Informant Hugh Croston
(b) Address Frostburg R7D#1

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-39 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Allegany

Location Frostburg

18 (a) Funeral director J J Dunst

(b) Address Frostburg

19 (a) 5-22-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. **Date of death** May 20 1939, at about 6:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1939, to May 20 1939, and that I last saw him alive on May 19 1939.

Immediate cause of death	Duration
Chronic Myocarditis	6 mo
Due to Arterio Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. **Signature** W. O. McLane Jr. M.D.
M. D. or other

Address Frostburg Md Date signed May 22 1939

RECEIVED
JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 14

(92a)

CERTIFICATE OF DEATH

04519

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Ellerslie (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Allegany

(c) City or town Ellerslie (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Mrs Frances M De Vore

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Charles De Vore

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25 1939

8. AGE: Years	Months	Days	If less than one day
73	1	8	hr. min.

9. Birthplace Mt. Savage Md. (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER

12. Name Isaac Shoemaker

13. Birthplace Md.

MOTHER

14. Maiden Name Sofie Guest

15. Birthplace Md.

16 (a) Informant Charles Miller

(b) Address Ellerslie Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6 1939 (month) (day) (year)

(c) Cemetery or crematory ***** Porters

Location Fords Mills Pa.

18 (a) Funeral director Harvey H. Zeigler

(b) Address Hyndman Pa.

19 (a) May 5 1939 (Date rec'd by registrar) (b) J. Lloyd Woolf Registrar

MEDICAL CERTIFICATION

20. Date of death May 3 1939, at 10.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1939, to May 3 1939, and that I last saw him alive on May 3 1939.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to Chronic Myocarditis	several years
Due to Arteriosclerosis	several years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. **Signature** J Barkley Hunter MD (M. D. or other)

Address Cumberland Md Date signed 5/4/39

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 8 1905
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (131)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

04520

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 300 Beall St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 50 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 Beall St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Soloman Samuel Diehl

3 (b) If veteran, name war —
3 (c) Social Security No. —

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Delia Whetstone
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 20 1853

8. AGE: Years 86 Months 2 Days 26 If less than one day hr. min.

9. Birthplace Bedford Co Pa. (Town, county, and state)
10. Usual occupation Merchant
11. Industry or business Grocery

FATHER
12. Name Henry P Diehl
13. Birthplace Pa.

MOTHER
14. Maiden Name Jane Smith
15. Birthplace Pa.

16 (a) Informant Chas H Diehl
(b) Address Cumberland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18 39 (month) (day) (year)
(c) Cemetery or crematory Greenmont Cem.
Location Cumberland

18 (a) Funeral director Louis Stein Tere
(b) Address 117 Frederick St.

19 (a) 5/17/39 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 16 1939, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1939, to May 16 1939, and that I last saw him alive on May 13 1939.

Immediate cause of death Chronic Nephritis — Duration 1 yrs
Due to Arteriosclerosis — 10 yrs
Due to
Other conditions None (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Gleason M.D. M. D. or other
Address 126 Union St. Date signed 5/16/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (17)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

04521

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 da
(e) Length of stay in this community (yrs., mos., or days) 46-8-16

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County Allegany
(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 Edgewood Drive (If rural give location)
(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Saloma Catherine Eichner

3 (b) If veteran, name war

3 (c) Social Security No.

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: G. W. Eichner

6. (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Sept 2 1892

8. AGE: Years 46 | Months 8 | Days 16 | If less than one day _____ hr. _____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Chris Roeder
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Schultz
15. Birthplace Germany

16 (a) Informant Memorial Hospital
(b) Address Cumberland, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20, 39 (month) (day) (year)
(c) Cemetery or crematory St Lukes Cem
Location Cumberland

18 (a) Funeral director Louis Stein Sons
(b) Address Cumberland, Md.

19 (a) 5/20/39 (Date rec'd by registrar) (b) J. Franklin, M.D. Registrar

Dr. Zimmerman-

MEDICAL CERTIFICATION

20. Date of death May 18, 1939, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 5, 1939, to May 18, 1939, and that I last saw him alive on 5-18-39 19_____.

Immediate cause of death	Duration
Encephalitis Lethargica	13 days
Due to —	
Due to —	
Other conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. C. Zimmerman M. D. or other
Address Cumberland Md. Date signed 5-19-39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-d)

CERTIFICATE OF DEATH

04522

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 9 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 925 GRAND A VE.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
BABY GIRL FEES — Adeste Jean Fees

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 22, 1939

8. AGE:

Years	Months	Days	If less than one day
		9	hrs. min.

9. Birthplace CUMBERLAND, MD.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name JOHN FEES
13. Birthplace OHIO

MOTHER
14. Maiden name DOROTHY KIRBY
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial Date thereof May 2 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cem
Location Cumberland, Md
18. Funeral director Louis Stein Inc
Address Cumberland, Md

19. 5/2/1939 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 1, 1939, at 11AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 22, 1939 to MAY 1, 1939
and that I last saw her alive on MAY 1 1939

Immediate cause of death: Intestinal Obstruction — DURATION 9 days
Due to Congenital Adhesion,
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of —
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) No
Means of injury None Injured at work? None.

23. SIGNATURE W R Hodges, M. D. or other
Address Cumberland Md Date signed 5/1/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DR. HODGES

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (94E)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

04523

1. PLACE OF DEATH:
(a) County ALLEGANY
(b) City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15DAYS
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State MD. (b) County ALLEGANY
(c) City or town LA VALE CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. LA VALE, CUMBERLAND, MD.
(If rural give location)
(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** MRS. MYRTLE FERGUSON

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife MR. DOUGLAS FERGUSON

6. (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) DEC. 17, 1890

8. AGE: Years 48 | Months 4 | Days 23 | If less than one day _____ hr. _____ min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name GEORGE S. WILLISON
13. Birthplace MARYLAND

MOTHER
14. Maiden Name RACHEL HITE
15. Birthplace MARYLAND

16 (a) Informant DOUGLAS FERGUSON
(b) Address LA VALE, CUMBERLAND, MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13-39 (month) (day) (year)
(c) Cemetery or crematory Hillcrest Cem.
Location Cumberland, Md

18 (a) Funeral director U. L. Lampshire
(b) Address 209 Frederick St. Cumberland, Md.

19 (a) 5/11/39 (Date rec'd by registrar) (b) J. L. Franklin, M.D. Registrar

DR. HAWKINS

MEDICAL CERTIFICATION

20. Date of death MAY 10, 1939 at 2:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 8, 1939, to May 10 1939, and that I last saw him alive on May 9, 1939.

Immediate cause of death Coronary Thrombosis — Duration 30 Minutes

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)
(e) Means of injury _____

23. Signature C. H. Hawkins M. D. or other
Address Cumberland Date signed 5-10, 39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH
Bureau of Vital Statistics, Baltimore (121)
Reg. Dist. No. 4

CERTIFICATE OF DEATH

04524

1. PLACE OF DEATH:
(a) County ALLEGANY
(b) City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days.
(e) Length of stay in this community (yrs., mos., or days) Life

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Cumberland Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 531 Washington St (If rural give location)
(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** THOMAS B. FINAN

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MARY MAUDE DOLAN FINAN

6. (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) JUNE 27 1878

8. AGE: Years 60 | Months 11 | Days 1 | If less than one day _____ hr. _____ min.

9. Birthplace MARYLAND Flintstone (Town, county, and state)

10. Usual occupation Capitalist

11. Industry or business

FATHER
12. Name PATRICK JOSEPH FINAN
13. Birthplace IRELAND

MOTHER
14. Maiden Name MARY ROACH
15. Birthplace IRELAND

16 (a) Informant MEMORIAL HOSPITAL
(b) Address CUMBERLAND, MARYLAND

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31, 39 (month) (day) (year)
(c) Cemetery or crematory St Patrick
Location Cumb'd Md

18 (a) Funeral director Louis Steinhour
(b) Address Cumberland Md

19 (a) May 31, 1939 (Date rec'd by registrar) (b) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. Date of death MAY 28 1939, at 4:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1939 to May 28 1939, and that I last saw him alive on _____

Immediate cause of death: Cyst of pituitary — Duration _____
Due to Hypotitis
Due to Gangrenous appendicitis
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings Gangrenous appendicitis
Of operation _____
Of autopsy Peritonitis — No.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature C H Hawkins M. D. or other
Address Cumberland Date signed 5-29-39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 6 1989
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (210-m) CB Reg. Dist. No. 9

CERTIFICATE OF DEATH

04525

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg, Md. (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Miners Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 min

(e) Length of stay in this community (yrs., mos., or days) 0

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Pa. (b) County Fayette

(c) City or town Masontown (If outside city or town limits, write RURAL and give town)

(d) Street No. — (If rural give location)

(e) If foreign born, how long in U. S. A.? 20 years ✓

3 (a) FULL NAME James Forgach

3 (b) If veteran, name war —

3 (c) Social Security No. 110-10-4051

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1918

8. AGE: Years 20 | Months 9 | Days 3 | If less than one day ___ hr. ___ min.

9. Birthplace Masontown, Pa. (Town, county, and state)

10. Usual occupation Worked in restaurant

11. Industry or business

FATHER 12. Name Valent Forgach

13. Birthplace Austria Hungary

MOTHER 14. Maiden Name Mary Bochack

15. Birthplace Austria Hungary

16 (a) Informant Mrs. M. A. Haney

(b) Address McClellandtown, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-6-39 (month) (day) (year)

(c) Cemetery or crematory St Marys

Location Masontown, Pa.

18 (a) Funeral director J. J. Durst

(b) Address Frostburg Md

19 (a) 5-6-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death 5-3- 1939, at 8:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-3 1939, to 5-3 1939, and that I last saw him alive on 5-3 1939.

Immediate cause of death	Duration
Fracture skull	5-3-39
Due to Hit by auto	5-3-39
~~Due to~~ Fracture left clavicle multiple abrasions and	5-3-39
Other conditions Lacerations head, face arms and legs. (Include pregnancy within 3 months of death)	5-3-39

Major findings:

Of operations no

Of autopsy no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 5-3-39

(c) Where did injury occur? Frostburg (City or town) Alleg. (County) Md. (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Route 40 Md. 1 mi. (Specify type of place) While at work? no. West of Frostburg, Md.

(e) Means of injury Hit by auto

23. Signature H. C. Diehl, M. D. (M. D. or other)

Address Frostburg, Md. Date signed 5-4-39

VS. A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 8 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (82a) Reg. Dist. No. 10

CERTIFICATE OF DEATH

04526

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Mt Savage (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 73yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Mt Savage (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Thomas Albert Geary.

3 (b) If veteran, name war | 3 (c) Social Security No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife Emma A. Geary
6. (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Oct 7, 1867.

8. AGE: Years 72 | Months 2 | Days 6 | If less than one day ____hr. ____min.

9. Birthplace Mt Savage Md. (Town, county, and state)
10. Usual occupation Boiler Maker.
11. Industry or business C & P. R.R. Co.
FATHER 12. Name Cornelius Geary
13. Birthplace Md.
MOTHER 14. Maiden Name Elizabeth Poland
15. Birthplace Md.
16 (a) Informant Glenn Geary
(b) Address Mt Savage Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16-1939 (month) (day) (year)
(c) Cemetery or crematory Methodist Cemetery
Location Mt Savage Md.
18 (a) Funeral director E. E. Burst
(b) Address Mt Savage, Md.
19 (a) 5-15-39 (Date rec'd by registrar) (b) H. A. Bostetter M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 13 1939, at 5.00 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1939, to May 13 1939, and that I last saw him alive on May 13 1939.

Immediate cause of death	Duration
Pneumonia,	2 days
Due to Hypostatic	10 days
Due to Arterio Sclerosis.	
Cerebral Hemorrhage; duration, six days.	
Other conditions Diabetes.	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. A. Bostetter M.D. (M. D. or other)
Address Mt Savage Md Date signed May 15-39

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 2 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 9

CERTIFICATE OF DEATH (200-C)

04527

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Borden Mine Md (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 68 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Borden Mines (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? 68 years

3 (a) FULL NAME William Thomas Gordon

3 (b) If veteran, name war —

3 (c) Social Security No. none

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Barbara Bennett Gordon

6. (c) If alive, give age 85 years

7. Birth date of deceased (mo., day, yr.) Apr. 4 1855

8. AGE: Years 84 Months 1 Days 1 If less than one day ____ hr. ____ min.

9. Birthplace Scotland (Town, county, and state)

10. Usual occupation Labor on R.R.

11. Industry or business Rep. Tracks

FATHER 12. Name James H. Gordon

13. Birthplace Scotland

MOTHER 14. Maiden Name Matilda Davis

15. Birthplace Scotland

16 (a) Informant Robert S. Gordon

(b) Address Borden Mines Md

17 (a) (Burial, cremation, or removal) (b) Date thereof May 8 1939 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Percy Cemetery

Location Frostburg Md

18 (a) Funeral director Jacob Hafer

(b) Address Frostburg Md

19 (a) 5-8-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death May 5 1939 at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from not at 19__ to all 19__, and that I last saw him alive on ____ 19__.

Immediate cause of death Unknown

~~Due to~~ No autopsy

Due to Dem.

Other conditions No further information. Civil R.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. C. Coley M. D. or other

Address Frostburg Date signed 5-6-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 4

04528

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Allegany Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in this community (yrs., mos., or days) 6 mo.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Pa (b) County Center
(c) City or town Smulltons (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Bernice R ~~[illegible]~~ Bernice R. Gosh

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. ~~Single~~ married

6 (b) Name of husband or wife Byron Gosh

6. (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Feb. 8. 1901

8. AGE: Years 38 Months 3 Days 2 If less than one day ____ hr. ____ min.

9. Birthplace Smulltons, Pa (Town, county, and state)

10. Usual occupation Musician

11. Industry or business Organist & Pianist

FATHER
12. Name Chas. Crouse
13. Birthplace Centre County Pa.

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Byron Gosh
(b) Address 231 N Center St Cumb.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12 1939 (month) (day) (year)
(c) Cemetery or crematory Smulltons, Pa
Location same

18 (a) Funeral director Jacob Hafer
(b) Address Cumberland Md

19 (a) 5/11/39 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 10 1939, at 11 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1939, to May 10 1939, and that I last saw him alive on May 10 1939.

Immediate cause of death	Duration
Chronic myocarditis	6 mos
Due to	
Due to	
Other conditions Malignant arterial hypertension (Include pregnancy within 3 months of death)	4 mos

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. A. Trevoskis M.D. M. D. or other
Address Cumberland, Md Date signed May 11-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 6 1909
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (46)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

04529

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Allegany Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County Allegany
(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(d) Street No. 28 Orchard St. (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Edward Nelson Gray

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1861

8. AGE: Years	Months	Days	If less than one day
77	4	29	____ hr. ____ min.

9. Birthplace Frederick, Maryland (Town, county, and state)
10. Usual occupation Carman
11. Industry or business W. Md. Railway

FATHER
12. Name Daniel T. Gray
13. Birthplace Antietam, Md.

MOTHER
14. Maiden Name Margaret Jones
15. Birthplace Jefferson Co. Md.

16 (a) Informant Samuel L. Gray
(b) Address 125 Oldtown Rd. Cumberland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22-39 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Greenmount
Location Cumberland Md

18 (a) Funeral director V. L. Lampe and
(b) Address Cumberland Md

19 (a) 5/20/39 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 19, 1939, at 11 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-14 1939, to 5-19 1939, and that I last saw him alive on 5-19 1939.

Immediate cause of death	Duration
Carcinoma of Stomach	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy General Carcinomatosis of all abdominal organs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. C. Bowen M.D. (M. D. or other)
Address Cumberland Date signed 5-19-39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-C)

Reg. Dist. No. Cobey 9

CERTIFICATE OF DEATH

04580

1. PLACE OF DEATH:

(a) County Allegany Co.

(b) City or town Frostburg, Md. (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Miner's Hospital, Frostburg, Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks.

(e) Length of stay in this community (yrs., mos., or days) 65 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Allegany

(c) City or town Frostburg, Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. 25 West Main St. (If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) **FULL NAME** Clara Belle Chaney Hart.

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex Female

5. Color or race White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband ~~or wife~~ John P. Hart

6. (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1873

8. **AGE:** Years 65 | Months 5 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Borden Shaft. (Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business At Home.

FATHER
12. Name Cambridge Graham Chaney
13. Birthplace Frostburg, Md.

MOTHER
14. Maiden Name Margaret E. Bawden
15. Birthplace England, London.

16 (a) Informant Bessie C. Statler

(b) Address 522 Cityview Terrace, Cumberland, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10, 1939 (month) (day) (year)

(c) Cemetery or crematory Allegany Cemetery

Location Frostburg, Maryland

18 (a) Funeral director Jacob Hafer

(b) Address Frostburg, Maryland

19 (a) 5-10-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death May 8, 1939 at 7.15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 15 1939, to May 8 1939, and that I last saw him alive on May 7 1939.

Immediate cause of death Chronic myocarditis

Due to Chronic pancreatitis

Due to Ulcers

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration: Unknown / Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. C. Cobey M. D. or other

Address Frostburg, Md. Date signed 5-8-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 6 1939
BUREAU V. S.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

WITHIN CORPORATE LIMITS

Bureau of Vital Statistics, Baltimore (73-C)

Reg. Dist. No. 9

CERTIFICATE OF DEATH

04531

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town Frostburg
(If outside city or town limits, write RURAL and give town)

(d) Street No. E Main
(If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** George W. Henry

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife Delphiene Henry

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 9-1864

8. AGE: Years	Months	Days	If less than one day
75	1	13	____ hr. ____ min.

9. Birthplace Lonaconing - Allegany - Md.
(Town, county, and state)

10. Usual occupation retired

11. Industry or business

FATHER
12. Name James Henry
13. Birthplace Winchester, Va.

MOTHER
14. Maiden Name Lydia Staup
15. Birthplace Md.

16 (a) Informant Mrs. Jonathan Sleeman
(b) Address Frostburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-39 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Allegany
Location Frostburg

18 (a) Funeral director J. D. Dent
(b) Address Frostburg

19 (a) 5-22-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. **Date of death** May 21 1939, at 2 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1938, to May 21 1939, and that I last saw him alive on May 19 19 39.

Immediate cause of death	Duration
Chronic Myocarditis	?
Due to Arterio Sclerosis	?
Due to Senility	?
Other conditions	

(Includa pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify typa of place) While at work?

(e) Means of injury

23. **Signature** W. D. McLane Jr M. D. or other

Address Frostburg Md Date signed May 22 1939

RECEIVED
JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (121) Reg. Dist. No. 6

CERTIFICATE OF DEATH

04532

1. PLACE OF DEATH:
(a) County: Allegany
(b) City or town: McCoole
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: West St.
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in this community (yrs., mos., or days): 49 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State: Md. (b) County: Allegany
(c) City or town: McCoole
(If outside city or town limits, write RURAL and give town)
(d) Street No.: West St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Americus Mason Hixenbaugh

3 (b) If veteran, name war: World War
3 (c) Social Security No.: 220-10-8905

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertie Rice Hixenbaugh
6. (c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Dec. 23, 1889

8. **AGE:** Years: 49 | Months: 3 | Days: 16 | If less than one day: ____hr. ____min.

9. Birthplace: McCoole, Allegany Co., Md.
(Town, county, and state)
10. Usual occupation: Plumber
11. Industry or business: Plumbing

FATHER
12. Name: Jno. W. Hixenbaugh
13. Birthplace: Do not know

MOTHER
14. Maiden Name: Martha Duckworth
15. Birthplace: Westernport, Md.

16 (a) Informant: C. E. Hixenbaugh
(b) Address: Keyser, W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/39 (month) (day) (year)
(c) Cemetery or crematory: Queen's Point
Location: Keyser, W. Va.

18 (a) Funeral director: R. H. Richmond
(b) Address: Keyser, W. Va.

19 (a) May 24 1939 (Date rec'd by registrar) (b) A. Baumbaker M.D. Registrar

MEDICAL CERTIFICATION

20. **Date of death** May 19 1939, at 10:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1939, to May 19 1939, and that I last saw him alive on May 19 1939.

Immediate cause of death	Duration
Pulmonary Edema	3 days
Due to Chronic Myocarditis	
Due to Chronic nephritis	
Other conditions 1	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: none
(b) Date of occurrence: none
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? none (Specify type of place) While at work?
(e) Means of injury: none

23. **Signature** J. C. Griffis M.D. (M. D. or other)
Address Keyser W Va Date signed 5-24-39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 3 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (99)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

04533

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Cumberland, (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in this community (yrs., mos., or days) 7 days

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County All

(c) City or town Lake (If outside city or town limits, write RURAL and give town)

(d) Street No. Main (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Mary Jack

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John Jack

6. (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1862

8. AGE: Years 77 Months 3 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace Scotland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William Blair

13. Birthplace Scotland

MOTHER 14. Maiden Name Helen Baird

15. Birthplace Scotland

16 (a) Informant Memorial Hospital

(b) Address Cumberland, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/39 (month) (day) (year)

(c) Cemetery or crematory Philos Cem

Location Westernport, Md.

18 (a) Funeral director D. S. Bool

(b) Address Westernport, Md.

19 (a) May 29, 1939 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 29 1939, at 2:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1939, to 5/29/39 19__, and that I last saw him alive on 5/29/39 19__.

Immediate cause of death Post Operative Shock

Due to Amputation of left limb due to embolus.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Richard J. Williams MD M. D. or other

Address 34 Va. Ave., Cumberland, Md. Date signed 5/29/39

Dr. Gracie-Dr. W. F. Williams

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (87-a) Reg. Dist. No. 9

CERTIFICATE OF DEATH

WITHIN CORPORATE LIMITS 04534

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Miners Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Frostburg Md (If outside city or town limits, write RURAL and give town)

(d) Street No. 113 Park Ave. (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Lloyd Ellerd Jackson

3 (b) If veteran, name war

3 (c) Social Security No. 215-03-4273

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	married

6 (b) Name of husband or wife Katie B. Cole

6. (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1878

8. AGE: Years	Months	Days	If less than one day
61	3	24	____ hr. ____ min.

9. Birthplace Frostburg, Md. (Town, county, and state)

10. Usual occupation Janitor

11. Industry or business Private Homes

FATHER 12. Name Benjamin Jackson

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Julia Mitchell

MOTHER 15. Birthplace Maryland

16 (a) Informant Mrs. Cole

(b) Address Piedmont W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12 1939 (month) (day) (year)

(c) Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18 (a) Funeral director Jacob Hafer

(b) Address Frostburg Md.

19 (a) 5-12-39 (Date rec'd by registrar) (b) Mrs. A. R. Weber Registrar

MEDICAL CERTIFICATION

20. Date of death May 9 1939, at 5-25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1939, to May 9 1939 and that I last saw him alive on May 9 1939.

Immediate cause of death	Duration
Cerebral hemorrhage	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. E. Cole M. D. or other

Address Frostburg Md Date signed 5-10-39

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (3)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

04535

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland, Md.
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Allegany Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County Allegany
(c) City or town Cumberland, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 Patterson Ave.,
(If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Baby Jones

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 6, 1939

8. AGE: Years | Months | Days | If less than one day: ____ hr. ____ min.

9. Birthplace Stillborn Cumberland, Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name John Jones
13. Birthplace Virginia

MOTHER
14. Maiden Name Maude Sutherland
15. Birthplace Cumberland, Md.

16 (a) Informant Father-John Jones
(b) Address 601 Patterson Ave.,

17 (a) Burial (Burial, cremation, or removal) Cumberland, Md. (b) Date thereof May 9, 1939 (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Md.

18 (a) Funeral director Louis Stein Inc.,
(b) Address Cumberland, Md.

19 (a) 5/9/39 (Date rec'd by registrar) (b) J. P. Thaukler, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 6, 1939 at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 afternoon 1939, to May 6 1939, and that I last saw him ~~alive~~ on May 6 1939.

Immediate cause of death	Duration
Prematurity (6 mths)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. P. Thaukler M. D. (M. D. or other)
Address 41 Green Cumberland Md. Date signed May 9/39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 6 1909
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (122-E) CB Reg. Dist. No. 4

04536

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Cumberland Md.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Allegany Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in this community (yrs., mos., or days) 2 days

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Pa. (b) County Somerset

(c) City or town Wellersburg
(If outside city or town limits, write RURAL and give town)

(d) Street No. Horn St.
(If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Gail Leah Jones

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John A. C. Jones

6. (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1916

8. AGE:

Years	Months	Days	If less than one day
23	3	17	_____ hr. _____ min.

9. Birthplace Mt. Carmel, Illinois
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name James L. Miller
13. Birthplace Unknown

MOTHER
14. Maiden Name Edna Pearl Long
15. Birthplace Wellersburg, Pa.

16 (a) Informant John A. C. Jones
(b) Address Wellersburg, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22, 39 (month) (day) (year)

(c) Cemetery or crematory Cooks Cem

Location near Wellersburg Pa.

18 (a) Funeral director Louis Stein Inc.

(b) Address Cumberland

19 (a) 5/22/39 (Date rec'd by registrar) (b) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 20 1939, at 3:05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1939, to May 20 1939, and that I last saw him alive on May 19 1939.

Immediate cause of death Intestinal obstruction from omental adhesions — Duration 3 days

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy adhesive bond omentum obstructing bowel

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ (Specify type of place) While at work? _____

(e) Means of injury _____

23. Signature W. Alfred Von Ormer, M.D.
M. D. or other

Address Cumberland, Md. Date signed 5-20-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (131) Reg. Dist. No. 4

CERTIFICATE OF DEATH

04537

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH

(a) County Allegany

(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 767 Maryland Ave

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED

(a) State Md. (b) County Allegany

(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(d) Street No. 767 Maryland Ave (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Mary Ellen Kennell

3 (b) If veteran, name war —

3 (c) Social Security No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Franklin S. Kennell

6. (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1879

8. AGE: Years 59 | Months 8 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Meyersdale, Pa. (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business At Home

FATHER 12. Name Samuel Butzell

13. Birthplace Meyersdale Pa

MOTHER 14. Maiden Name Amelia Albright

15. Birthplace Meyersdale, Pa

16 (a) Informant F. P. Kennell

(b) Address Cumberland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14, 1939 (month) (day) (year)

(c) Cemetery or crematory Rose Hill Cem.

Location Cumberland

18 (a) Funeral director Jacob Lufy

(b) Address Cumberland, Md

19 (a) 5/13/39 (Date rec'd by registrar) (b) J. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 11, 1939, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 10, 1939, to May 11, 1939, and that I last saw him alive on May 11, 1939.

Immediate cause of death	Duration
Acute Myocardial Failure	5-11-39
Due to Cardio Renal Vascular Disease	1935?
Due to Cardiac Asthma	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Arthur L. Jones M.D. (M. D. or other)

Address Cumberland Date signed 5/13/39

RECEIVED
JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (92-21) Reg. Dist. No. 8

CERTIFICATE OF DEATH

04538

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Midland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: c
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 15 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Midland, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. c (If rural give location)
(e) If foreign born, how long in U. S. A.? c years

3 (a) FULL NAME Stanton Kidwell

3 (b) If veteran, name war c

3 (c) Social Security No. 214059742

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Jeannette Jackson

6. (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) June 2, 1910

8. AGE: Years 28 | Months 11 | Days 25 | If less than one day ____hr. ____min.

9. Birthplace Maryland (Town, county and state)

10. Usual occupation Oil Well Worker

11. Industry or business Oil Prod.

FATHER
12. Name George Kidwell
13. Birthplace West Virginia

MOTHER
14. Maiden Name Nettie Tappes
15. Birthplace West Virginia

16 (a) Informant Mrs. Jeannette Kidwell
(b) Address Midland, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 30, 1939 (month) (day) (year)
(c) Cemetery or crematory Shilos Cemetery
Location Westernport, Md.

18 (a) Funeral director Mc Eachron
(b) Address Frostburg, Md.

19 (a) May 29-1939 (Date rec'd by registrar) (b) Dr. E. Dorsey Registrar

MEDICAL CERTIFICATION

20. Date of death May 27 1939, at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1939 to May 27 1939, and that I last saw him alive on May 27 1939.

Immediate cause of death Coronary Occlusion — Duration 3 days

Due to

Due to

Other conditions Rheumatic Endocarditis — 1-2 yrs.

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. M. Shelton Jr. M D. (M. D. or other)
Address Midland, Md Date signed 5-29-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 6 1939
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (166) Reg. Dist. No. 4

CERTIFICATE OF DEATH

04539

1. PLACE OF DEATH

(a) County Allegany

(b) City or town Frostburg, Md. (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town near Lonaconing, Md. R.F.D. (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Arabata Killen

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Harry Killen

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1882

8. AGE: Years 57 | Months 0 | Days 23 | If less than one day hr. min.

9. Birthplace Ada, Ohio (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William T. Harmon

13. Birthplace Ohio

MOTHER 14. Maiden Name Marsetta Claybaugh

15. Birthplace Ada, Ohio

16 (a) Informant James Clifford Killen

(b) Address Lonaconing Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/39. (month) (day) (year)

(c) Cemetery or crematory Westmoreland Park.

Location Westmoreland Memorial Pa

18 (a) Funeral director Louis Stein Greensburg Pa

(b) Address Greensburg Pa

19 (a) May 30 1939 (Date rec'd by registrar) (b) J. L. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. Date of death about May 29 1939, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1939, to May 30 1939, and that I last saw him alive on May 30 1939. Her Dead

Immediate cause of death	Duration
Strangulation	Immediate
Due to Falling in water Braddock Run	
Due to	
Other conditions Despondent since Death of Husband Feb 1939 (Include pregnancy within 3 months of death)	

Major findings:

Of operations No water in lungs

Of autopsy Stomach half full of water

PHYSICIAN

Underlins the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Suicide

(b) Date of occurrence About 5-29/39 - 10:45 PM

(c) Where did injury occur? near LaVale Sub (Town) Cumberland (County) Allegany (State) Md

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? No

(e) Means of injury

23. Signature H. V. Deming M.D. (Coroner) M. D. or other

Address May 30 67 W. Center St Date signed 5-30/39

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-C)

Reg. Dist. No. 9

M & Lane

CERTIFICATE OF DEATH

04540

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 11 High St.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4

(e) Length of stay in this community (yrs., mos., or days) Life

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(d) Street No. 11 Hight St (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Conrad Knieriem

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Susan Knieriem

6. (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Oct 15 - 1864

8. AGE: Years 74 Months 7 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Frostburg - Allegany - Md. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business School

FATHER

12. Name Peter Knieriem

13. Birthplace Germany

MOTHER

14. Maiden Name Rachel Daugletree

15. Birthplace Md

16 (a) Informant Oscar Knieriem

(b) Address Frostburg Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-39 (month) (day) (year)

(c) Cemetery or crematory Allegany

Location Frostburg Md

18 (a) Funeral director J. J. Dupont

(b) Address Frostburg

19 (a) 5-22-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death May 20 1939, at 7 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1939, to May 20 1939, and that I last saw him alive on May 20 1939.

Immediate cause of death	Duration
Chronic Myocarditis	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. O. McLane Jr. MD M. D. or other

Address Frostburg Md Date signed May 22 1939

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 4

CERTIFICATE OF DEATH

(820)

04541

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Allegany Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 50 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(d) Street No. 625 Columbia Ave. (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Hannah E Kiffner

3 (b) If veteran, name war ____

3 (c) Social Security No. ____

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John W Kiffner

6. (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Oct 18 1866

8. **AGE:** Years 72 Months 6 Days 27 If less than one day ____ hr. ____ min.

9. Birthplace Lonaconing, Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Geo Schaffer

13. Birthplace Germany

MOTHER 14. Maiden Name Margaret

15. Birthplace Germany

16 (a) Informant Walter Kiffner

(b) Address Cumberland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18 39 (month) (day) (year)

(c) Cemetery or crematory Trinity Lutheran

Location Cumberland

18 (a) Funeral director Louis Stein Inc.

(b) Address 117 Frederick St.

19 (a) 5/17/39 (Date rec'd by registrar) (b) J. T. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 10 1939, at 8 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1939, to May 10 1939, and that I last saw him alive on May 14 1939.

Immediate cause of death Hemiplegia apoplexy — 0 days

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature C. F. W. Snyder M. D. or other

Address Cumberland Date signed 5-16-39

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 1 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (82a)

Reg. Dist. No. 8

CERTIFICATE OF DEATH

04542

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Lonaconing, Rt. (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution Rockville

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 43 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Allegany

(c) City or town Lonaconing, Rt. (If outside city or town limits, write RURAL and give town)

(d) Street No. Rockville (If rural give location)

(e) If foreign born, how long in U. S. A.? ✓ years

3 (a) **FULL NAME** Martha Jenkins Lancaster

3 (b) If veteran, name war ✓

3 (c) Social Security No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife David Lancaster

6. (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Nov. 30 1866

8. AGE: Years	Months	Days	If less than one day
72	5	21	____hr. ____min.

9. Birthplace Midland, Allegany Co., Md. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business None

FATHER 12. Name John Edgar Jenkins

FATHER 13. Birthplace Wales

MOTHER 14. Maiden Name Sara Anne Bird

MOTHER 15. Birthplace Wales

16 (a) Informant Mrs. Thomas Wilson

(b) Address Lonaconing, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23 1939 (month) (day) (year)

(c) Cemetery or crematory St. Lawrence Cemetery

Location Frostburg, Md.

18 (a) Funeral director Wm. Eichhorn

(b) Address Lonaconing, Md.

19 (a) May 22 1939 (Date rec'd by registrar) (b) Wm. E. Eichhorn Registrar

MEDICAL CERTIFICATION

20. Date of death May 21 1939, at 7.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1939, to May 21 1939, and that I last saw him alive on May 20 1939.

Immediate cause of death	Cerebral Hemorrhage	Duration
Due to	Cerebral Sclerosis	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. **Signature** H. Harry M. Hodgson M.D. (M. D. or other)

Address Lonaconing Md. Date signed May 22 39

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

WITHIN CORPORATE LIMITS

Bureau of Vital Statistics, Baltimore (131)

Reg. Dist. No. 9

CERTIFICATE OF DEATH

04543

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 136 Bowery St.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 1yr.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Allegany

(c) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(d) Street No. 136 Bowery Street. (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** Mrs. Virginia Largent

3 (b) If veteran, name war

3 (c) Social Security No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem.	White	Widowed

6 (b) Name of husband or wife Benjamin Largent

6. (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) July 8, 1863

8. AGE: Years	Months	Days	If less than one day
75	9	27	_____ hr. _____ min.

9. Birthplace Short Gap W. Va. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Isaac Long

FATHER 13. Birthplace West Virginia

MOTHER 14. Maiden Name Catherine Forber

MOTHER 15. Birthplace Pennsylvania.

16 (a) Informant George Long

(b) Address 66 Centennial St. Frostburg

17 (a) Burial (Burial, cremation, or removal) Buried (b) Date thereof May 8, 1939 (month) (day) (year)

(c) Cemetery or crematory Monnett Cem.

Location Near Fort Ashby W. Va.

18 (a) Funeral director J. C. Wolford

(b) Address Cumberland, Md.

19 (a) 5-6 '39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death May 5 1939, at 9 20/24 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1939, to May 5 1939, and that I last saw him alive on dead on arrival 19_____.

Immediate cause of death	Duration
Pulmonary Embolism	
Due to Chronic Cardio Vascular renal disease	
Due to Patient never seen before this visit	
Other conditions Dead on arrival	

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide no

(b) Date of occurrence no

(c) Where did injury occur? (City or town) (County) (State) no

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) no While at work? no

(e) Means of injury no.

23. Signature Allen Kilday, M.D. M. D. or other

Address 56 West Main Street Frostburg Md. Date signed 5/5/39

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

STATE OF MARYLAND—CERTIFICATE OF DEATH

04544

1. PLACE OF DEATH (159)

County Allegany Registration Dist. No. 4

Village or City Cumberland No. Allegany Hospital St., 4-1 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Baby Girl Leasure If U. S. Veteran, specify WAR ____

(a) Residence: No. 119 Hanover St., ____ Ward. ____

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) May 27 - 39

7. AGE Years — Months — Days — If LESS than 1 day, 10 hrs. or ____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. none

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. X

10. Date deceased last worked at this occupation (month and year) ____ 11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) (State or country) Cumberland Md

FATHER

13. NAME Harvey Shanholtz

14. BIRTHPLACE (city or town) (State or country) W. Va

MOTHER

15. MAIDEN NAME Alice Leasure

16. BIRTHPLACE (city or town) (State or country) Cumberland, Md

17. INFORMANT Mr Robert Long (Address) 119 Hanover St. City

18. BURIAL, CREMATION, OR REMOVAL Place Rose Hill Cme Date May 29, 1939

19. UNDERTAKER V. L. Lemperour (Address) Cumberland, Md.

20. FILED May 29, 1939 J. P. Franklin, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 27 (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 27, 1939, to May 27, 1939

I last saw her alive on May 27, 1939; death is said to have occurred on the date stated above, at 1:40 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Prematurity (34 wks gestation)	5-27-39

Other Contributory Causes of Importance:

Name of operation None Date of ____

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of Injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury ____

Nature of Injury ____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify ____

(Signed) Arthur A. Jones M. D.

(Address) 40 N. Liberty St.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

RECEIVED JUN 8 1928 BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 04545

(46C)

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg-RFD (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 41 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State M (b) County Allegany

(c) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(d) Street No. 2 Ormond (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** Arthur H. Lemmert

3 (b) If veteran, name war —

3 (c) Social Security No. 213-05-7163

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Eleanor Hartman

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Jan 13-1898

8. **AGE:** Years 41 Months 4 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Frostburg Alleg. Md. (Town, county, and state)

10. Usual occupation Chauffer

11. Industry or business Bus

FATHER

12. Name W M Lemmert

13. Birthplace Frostburg

MOTHER

14. Maiden Name Sarah E. Hannah

15. Birthplace Frostburg

16 (a) Informant Mrs A. Lemmert

(b) Address Frostburg Md.

17 (a) _____ (Burial, cremation, or removal) (b) Date thereof May 24-39 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Allegany

Location Frostburg

18 (a) Funeral director J J Dwyer

(b) Address Frostburg Md.

19 (a) 5-22-39 (Date rec'd by registrar) (b) Mrs. A. R. Naeker Registrar

MEDICAL CERTIFICATION

20. Date of death May 22 1939, at 6.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1938, to May 22 1939, and that I last saw him alive on May 21 1939.

Immediate cause of death Carcinoma of Descending Colon — Duration 6 mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings: Laparotomy

Of operations Colostomy

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W D McLane Jr MD M. D. or other

Address Frostburg Md Date signed May 22 1930

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M) (I) (T)

RECEIVED
JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (186-a) Reg. Dist. No. 04546

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Moscow, Md.
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 42 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Moscow
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Francis Humphrey Lewellyn

3 (b) If veteran, name war —
3 (c) Social Security No. —

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Sarah Lewellyn
Dead
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22 1870

8. AGE: Years 68 Months 7 Days 6 If less than one day hr. min.

9. Birthplace Near Frostburg
(Town, county, and state)
10. Usual occupation Coal - Miner
11. Industry or business Digging coal

FATHER
12. Name John Lewellyn
13. Birthplace Gilmore, Md.

MOTHER
14. Maiden Name Sarah Loar
15. Birthplace Loartown, Md.

16 (a) Informant Nelson O. Llewellyn
(b) Address Barton Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31, 1939 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Laurel Hill - Moscow

18 (a) Funeral director D. S. Boal
(b) Address Barton, Md.

19 (a) May 29 (Date rec'd by registrar) (b) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. Date of death May 28 1939, at 6:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 28 1939, to May 28 1939, and that I last saw him alive on May 28 1939.

Immediate cause of death	Duration
Cerebral Hemorrhage	5/27/39
Due to arteriosclerosis	1929
Due to	
Other conditions Fell down stairs after stroke	5/27/39

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. E. Berry M. D. or other
Address Piedmont W. Va Date signed 5/29/39

VS. A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (108) CB

Reg. Dist. No. 4

CERTIFICATE OF DEATH

04547

1. PLACE OF DEATH:
(a) County ALLEGANY
(b) City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in this community (yrs., mos., or days) ____

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State W.VA. (b) County HAMPSHIRE
(c) City or town SPRINGFIELD (If outside city or town limits, write RURAL and give town)
(d) Street No. ____ (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME: LOGSTON, RALPH MR.

3 (b) If veteran, name war: ____ | 3 (c) Social Security No.: ____

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife ____ 6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) JUNE 14, 1914

8. AGE: Years	Months	Days	If less than one day
24	11	17	____ hr. ____ min.

9. Birthplace ILLINOIS (Town, county, and state)
10. Usual occupation LABORER
11. Industry or business

FATHER
12. Name LOGSTON, JAMES
13. Birthplace W.VA.

MOTHER
14. Maiden Name CROCK, DAISY
15. Birthplace W.VA.

16 (a) Informant MEMORIAL HOSPITAL
(b) Address CUMBERLAND, MARYLAND

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2 1939 (month) (day) (year)
(c) Cemetery or crematory Springfield Cem
Location Springfield W. Va

18 (a) Funeral director W. Bruckee
(b) Address Augusta, W. Va.

19 (a) 5/31/39 (Date rec'd by registrar) (b) J. T. Franklin M.D. Registrar

DR. ENFIELD

MEDICAL CERTIFICATION

20. Date of death MAY 31, 1939 at 11:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 19 39 to May 31 19 39
and that I last saw him alive on May 31 19 39

Immediate cause of death	Duration
Septicaemia	
Due to Pneumonia Right-lobar	
Due to Emphysema	
Other conditions Tonsilitis & Jaundice	

(Include pregnancy within 3 months of death)

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature A E Enfield. M. D. or other
Address Cumberland Date signed 6/31/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
JUN 6 1939
BUREAU V. S.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 8

04548

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Lonaconing (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: West Main St.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 69½

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Allegany

(c) City or town Lonaconing (If outside city or town limits, write RURAL and give town)

(d) Street No. West Main (If rural give location)

(e) If foreign born, how long in U. S. A.? 72 years

3 (a) FULL NAME Robert Marshall, Jr.

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Margaret McKinley

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 29, 1845

8. AGE: Years 93 Months 4 Days 10 If less than one day ___ hr. ___ min.

9. Birthplace Lancashire Scotland (Town, county, and state)

10. Usual occupation Retired Carpenter

11. Industry or business —

FATHER

12. Name T. — Marshall

13. Birthplace Scotland

MOTHER

14. Maiden Name Unknown

15. Birthplace Scotland

16 (a) Informant James O. Marshall

(b) Address Lonaconing, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12, 1939 (month) (day) (year)

(c) Cemetery or crematory Oak Hill Cemetery

Location Lonaconing, Md.

18 (a) Funeral director M. Eichhorn

(b) Address Lonaconing, Md.

19 (a) May 12 1939 (Date rec'd by registrar) (b) Dr. E. Dan Tylor Registrar

MEDICAL CERTIFICATION

20. Date of death May 9 1939, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5th 1939, to May 9th 1939, and that I last saw him alive on May 9 1939.

Immediate cause of death Bronchio Pneumonia

Due to

Due to

Other conditions Senility

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Henry M. Hodgson M.D. M. D. or other

Address Lonaconing, Md. Date signed 5/9/39

RECEIVED
JUN 6 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (74) Reg. Dist. No. 8

CERTIFICATE OF DEATH

04549

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Lonaconing (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Church Street
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 2 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County Allegany
(c) City or town Lonaconing (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Munroe M. Walsh McGinn

3 (b) If veteran, name war —
3 (c) Social Security No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John H. McGinn
6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 21, 1878

8. AGE: Years 60 | Months 10 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Lonaconing Md. (Town, county, and state)
10. Usual occupation Housework
11. Industry or business Home

FATHER
12. Name Edward Walsh
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Reynolds
15. Birthplace Hagerstown Md.

16 (a) Informant Miss Mary Walsh
(b) Address Lonaconing Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 30 1939 (month) (day) (year)
(c) Cemetery or crematory St. Patricks, Courtesy
Location Cumberland, Md.

18 (a) Funeral director M. Eichhorn
(b) Address Lonaconing Md.

19 (a) May 29 1939 (Date rec'd by registrar) (b) D. E. Duffy Registrar

MEDICAL CERTIFICATION

20. Date of death May 28 1939, at 8-50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw him alive on ____ 19____.

	Duration
Immediate cause of death Coronary Thrombosis	Sudden death
Due to	
Due to	
Other conditions Chronic Bronchitis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry M. Hodgson M.D. (M. D. or other)
Address Lonaconing Md. Date signed 5/29/39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (124B)

Reg. Dist. No. 9

04550

CERTIFICATE OF DEATH

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Miners Hospital

(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 3

(e) Length of stay in this community (yrs., ~~mos.~~, or ~~days~~) 40

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(d) Street No. 118 Centre (If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Joseph McGraw

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23 - 1878

8. AGE: Years 61 Months 8 Days 5 If less than one day hr. min.

9. Birthplace Piedmont W Va (Town, county, and state)

10. Usual occupation

11. Industry or business Pool Room

FATHER 12. Name John McGraw

13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret Reynolds

15. Birthplace Mt Savage Md

16 (a) Informant Mary McGraw

(b) Address Frostburg Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof May 30-39 (month) (day) (year)

(c) Cemetery or crematory St Michaels Cem.

Location Frostburg Md

18 (a) Funeral director J. J. Hurst

(b) Address Frostburg

19 (a) 5-30-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death May 28 1939, at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-23 1939, to 5-28 1939, and that I last saw him alive on 5-28 1939.

Immediate cause of death Chronic glomerular nephritis — Duration 6 mos.

Due to Hypertensive cardio-vascular disease — 2 or 3 years

Due to

Other conditions Cirrhosis of liver 2 or 3 years

(Include pregnancy within 3 months of death)

Major findings:

Of operations none.

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. C. Diehl, M. D. (M. D. or other)

Address Frostburg, Md. Date signed 5-29-39.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (22-A) Reg. Dist. No. 9

CERTIFICATE OF DEATH

04551

1. PLACE OF DEATH:

(a) County Allegany County

(b) City or town Rural, Borden Shaft. (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) Life

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Allegany

(c) City or town Rural, Borden Shaft, Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. — (If rural give location)

(e) If foreign born, how long in U. S. A.? ——— years

3 (a) FULL NAME James M. McGregor

3 (b) If veteran, name war: no

3 (c) Social Security No. 217-10-4245

4. Sex: Male

5. Color or race: White.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Agnes Harvey McGregor

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) June 19, 1885

8. AGE: Years 53 | Months 10 | Days 25 | If less than one day ——hr. ——min.

9. Birthplace Midlothian Md (Town, county, and state)

10. Usual occupation Boiler Maker Helper

11. Industry or business Textile Business.

FATHER 12. Name Robert McGregor

FATHER 13. Birthplace Roundtree, Scotland

MOTHER 14. Maiden Name Ellen McAlpine

MOTHER 15. Birthplace Scotland

16 (a) Informant Harvey McGregor

16 (b) Address Borden Shaft, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16, 1939 (month) (day) (year)

17 (c) Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18 (a) Funeral director Jacob Hafer

18 (b) Address Frostburg, Md.

19 (a) 5—16'39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death May 14, 1939, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 17 1939, to May 14 1939 and that I last saw him alive on May 1, 1939

Immediate cause of death	Duration
Found Dead apparently — Cerebral Hemorrhage	?
Due to Hypertension	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. D. McGregor M.D. (M.D. or other)

Address Frostburg Date signed May 15 1939

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (75)

Reg. Dist. No. 9

04552

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 18 Stayer St.

(d) Length of stay in hospital or inst. (yrs., mos., or days) ?

(e) Length of stay in this community (yrs., mos., or days) Life

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(d) Street No. 18 Stayer (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Edward McKenzie

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Beaver

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug 24-1864

8. AGE: Years 74 Months 8 Days 28 If less than one day _____ hr. _____ min.

9. Birthplace Frostburg Alleg. Md (Town, county, and state)

10. Usual occupation carpenter

11. Industry or business —

FATHER

12. Name Geo. A. McKenzie

13. Birthplace Somerset, Pa.

MOTHER

14. Maiden Name Mary L. McKenzie

15. Birthplace Maryland

16 (a) Informant Lincoln McKenzie

(b) Address Frostburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-25-39 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Terry

Location Frostburg Md.

18 (a) Funeral director J J Durst

(b) Address Frostburg

19 (a) 5-25 39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death 5-22 1939, at (?) M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-24 1939, to 5-24 1939, and that I last saw him ~~alive~~ dead on 5-24 1939.

Immediate cause of death ?

Due to Chronic alcoholism

Due to

Other conditions

(Include pregnancy within 3 months of death)

Duration: at once; several yrs.

Major findings:

Of operations Body badly decomposed found in a garage. Last seen by

Of autopsy Chief of police 5-22-39 evening

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. V. Dining M.D. (Coroner) M. D. or other

Address 67 N Center St Cumberland Md

Date signed 5-24/39

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (57) Reg. Dist. No. 8

CERTIFICATE OF DEATH

04553

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Lonaconing, Md.
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution Jackson Street
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 50 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Lonaconing
(If outside city or town limits, write RURAL and give town)
(d) Street No. Jackson, S Street
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) **FULL NAME** Janet Lashbaugh Metz

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Alb. Metz

6. (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1880

8. AGE: Years 59 | Months 3 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Barton, Allegany Co. Md
(Town, county and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER
12. Name Benjamin Lashbaugh
13. Birthplace Barton, Md

MOTHER
14. Maiden Name Sara Greenhorn
15. Birthplace Barton, Md

16 (a) Informant Mrs. Raymond Metz
(b) Address Lonaconing, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1, 1939 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cemetery
Location Lonaconing, Md

18 (a) Funeral director W. Eichhorn
(b) Address Lonaconing, Md

19 (a) May 31 1939 (Date rec'd by registrar) (b) Dr. E. Don Taylor Registrar

MEDICAL CERTIFICATION

20. Date of death May 28 1939, at 9.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1939, to May 28 1939, and that I last saw him alive on May 15 1939.

	Duration
Immediate cause of death: Coronary Occlusion	6 mo
Due to: Arteriosclerosis	1 yr
Due to:	
Other conditions: Diabetes Mellitus (Include pregnancy within 3 months of death)	14 yr

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Norman Reese M.D. (M. D. or other)
Address Westernport Date signed 5-30-39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (8)

Reg. Dist. No. 10

04554

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Barnesville
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) Still Born

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Barnesville
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Michaels.

3 (b) If veteran, name war
3 (c) Social Security No.

4. Sex Still
5. Color or race W
6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife Born
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22. 1939.

8. AGE: Years Still | Months | Days Born | If less than one day hr. min.

9. Birthplace Barnesville Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Wilbur P. Michaels
13. Birthplace Md

MOTHER
14. Maiden Name Edna Claire Kellar
15. Birthplace Md. a.

16 (a) Informant Wilbur P. Michaels
(b) Address Wellersburg Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22. 1939 (month) (day) (year)
(c) Cemetery or crematory Michaels
Location Barnesville

18 (a) Funeral director Wilbur P. Michaels (father)
(b) Address Wellersburg Pa

19 (a) May 22. 1939 (Date rec'd by registrar) (b) H. J. Bostetter M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 22 1939, at 11:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Still Born 19, to 19, and that I last saw him alive on 19.

Immediate cause of death Premature Birth 3 month

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Bostetter M.D. M. D. or other

Address Mt Savage Md. Date signed 5/22-39

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 2 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 9

CERTIFICATE OF DEATH

04555

VS. A15 — MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Rural (Frostburg, Md. (Shaft)) (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Shaft, Md - Frostburg, Md., R.D.#1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 40 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Shaft (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Scott Winfield Miller

3 (b) If veteran, name war: no
3 (c) Social Security No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Margaret Muir Miller
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) July 3-1862

8. AGE: Years 77 | Months 10 | Days 3 | If less than one day ____hr. ____min.

9. Birthplace Aviston Ill. (Town, county, and state)
10. Usual occupation Coal Miner
11. Industry or business

FATHER
12. Name Christopher Miller
13. Birthplace Md

MOTHER
14. Maiden Name Jane Warnick
15. Birthplace Md

16 (a) Informant Leonard Miller
(b) Address RR #1 Frostburg Md

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof May 9 1939 (month) (day) (year)
(c) Cemetery or crematory Allegany Cemetery
Location Frostburg Md

18 (a) Funeral director Jacob Reaper
(b) Address Frostburg Md.

19 (a) 5-9-'39 (Date rec'd by registrar) (b) Mrs. A.R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death May 6 1939, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 16 1939, to May 6 1939, and that I last saw him alive on Apr 16 1939.

Immediate cause of death	Duration
Chronic Myocarditis	6 mo
Due to	
Due to	
Other conditions Chr. Bronchitis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W.O.M. Lane M.D. (M. D. or other)
Address Frostburg Md Date signed May 8 1939

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 49-8 CB

Reg. Dist. No. 4

CERTIFICATE OF DEATH

04556

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

(a) County: Allegany

(b) City or town: Cumberland, Maryland. (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Allegany Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 15 days

(e) Length of stay in this community (yrs., mos., or days):

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State: W.Va. (b) County:

(c) City or town: Berkeley S prings (If outside city or town limits, write RURAL and give town)

(d) Street No.: Congress St. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Mrs. Alice Virginia Moore

3 (b) If veteran, name war:

3 (c) Social Security No.:

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Richard Moore

6. (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 16, 1883

8. AGE: Years: 56 Months: 1 Days: 18 If less than one day: hr. min.

9. Birthplace: Martinsburg, W.Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Holly Hensell

13. Birthplace: Md

MOTHER 14. Maiden Name: Nannie Harbaugh

15. Birthplace: Md

16 (a) Informant: Son - Clifford Moore

(b) Address: Berkeley Springs, W.Va.

17 (a) Burial & Removal (Burial, cremation, or removal) (b) Date thereof May 7, 1939 (month) (day) (year)

(c) Cemetery or crematory: Greenway

Location: Berkeley Springs W.Va.

18 (a) Funeral director: C. I. Trostler

(b) Address: Berkeley Springs, W.Va.

19 (a) 5/5/39 (Date rec'd by registrar) (b) J. F. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death: May 4 19 39, at 2:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15-38 19 to 5-4-39 19, and that I last saw him alive on 5-4-39 19.

	Duration
Immediate cause of death: Carcinomatosis	7 days.
Due to: Carcinoma of Vagina	4 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: Carcinoma of vaginal wall & metastasis to abdomen

Of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: [signature] M. D. or other

Address: [illegible] Md Date signed: 5-5-39

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

04557

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution 407 Race

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 30 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany.

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 407 Race St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Michael J. Moore.

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Minnie Leonard

6(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) May 1 1881

8. AGE: Years 58 Months — Days 30 If less than one day ___ hrs. ___ min.

9. Birthplace Martinsburg W. Va.
(Town, county, and state)

10. Usual occupation Conductor R. R.

11. Industry or business Retired 1932

FATHER
12. Name Patrick Moore.
13. Birthplace Ireland.

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Jas Moore.

Address 407 Race St.

17. Burial Date thereof June 3 '39
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sts Peter & Pauls Cem

Location Cumberland.

18. Funeral director Louis Stein Inc.

Address Cumberland.

19. June 2 1939 J. P. Franklin, M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH J May 31, 1939, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1936, to May 31, 1939, and that I last saw him alive on May 30, 1939.

Immediate cause of death Uraemia
Chronic Myocarditis

Due to Right Cerebral Haemorrhage
Left Hemiplegia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION
4/39
1936
Aug 1936

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay E. Durrett
M. D. or other

Address Cumberland, Md Date signed June 2, 1939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04558

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 534 Greene St.
Stay in hospital or inst. (yrs., or mos., or days) 47-11-19
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 534 Greene
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Raymond Morehead

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Margarite Sell
6(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): June 12 1891

8. AGE: Years	Months	Days	If less than one day
47	11	19	hrs. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)
10. Usual occupation: Merchant.
11. Industry or business: Sheet Metal
FATHER 12. Name: Thos. Morehead
13. Birthplace: Md.
MOTHER 14. Maiden name: Ellen Mc Farran
15. Birthplace: Md.
16. Informant: Mrs. J. R. Morehead
Address: Cumberland,
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 3 39 (month) (day) (year)
Cemetery or crematory: St. Peter & Pauls Cem.
Location: Cumberland Md.
18. Funeral director: Louis Stein Inc.
Address: Cumberland
19. June 2 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 1939, at 11 Q M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 1939, to May 31 1939, and that I last saw him alive on May 31 1939

Immediate cause of death	DURATION
Coronary Thrombosis	1/4 hour
Due to	
Due to	
Other conditions: Arterio Sclerosis	2 yrs

(Include pregnancy within 3 months of death)

Major findings:
Df operations: -
Df autopsy: -

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of: -
Where did injury occur? - (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -
Means of injury: - Injured at work? -

23. SIGNATURE: Hoff. A. Rood M. D. or other
Address: Cumberland Md. Date signed June 1-39

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (97)

Reg. Dist. No. 4

04559

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland Md.
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: County Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in this community (yrs., mos., or days) 21 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Cumberland Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 Decatur
(If rural give location)
(e) If foreign born, how long in U. S. A.? 77 years

3 (a) FULL NAME Carrie Morrison

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5, 1862

8. AGE: Years 77 | Months 4 | Days | If less than one day ____hr. ____min.

9. Birthplace Westernport, Md.
(Town, county, and state)

10. Usual occupation Music Teacher

11. Industry or business

FATHER
12. Name John Morrison
13. Birthplace Barton Md.

MOTHER
14. Maiden Name Carrie Ward
15. Birthplace Mt. Savage, Md.

16 (a) Informant County Home Reference
(b) Address Cumberland, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7 1939 (month) (day) (year)
(c) Cemetery or crematory Maryland Cemetery
Location Reynolds, Md.

18 (a) Funeral director Boyd & Boal
(b) Address Westernport Md.

19 (a) 5/9/39 (Date rec'd by registrar) (b) J. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 5 1939, at 5:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1939 to May 5 1939 and that I last saw him alive on May 4 1939.

Immediate cause of death Arteriosclerosis — Duration ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. F. Williams M. D. or other
Address Cumberland Date signed 5-8-39

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

RECEIVED
JUN 8 1989
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (942) (B) Reg. Dist. No. 4

CERTIFICATE OF DEATH

04560

1. PLACE OF DEATH:
(a) County Allegany County
(b) City or town Cumberland, Maryland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State W. Va. (b) County Hampshire
(c) City or town Romney (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME: Talmage Newhouse

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Bessie Heavner

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1894

8. AGE: Years 45 | Months 3 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business

FATHER
12. Name: Edwin Newhouse
13. Birthplace: West Virginia

MOTHER
14. Maiden Name: Florence Bobo
15. Birthplace: West Virginia

16 (a) Informant: Memorial Hospital
(b) Address: Cumberland Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2-39 (month) (day) (year)
(c) Cemetery or crematory Indian Mound Cemetery
Location: Romney, W. Va.

18 (a) Funeral director: Thrush's
(b) Address: Romney W. Va.

19 (a) June 1 1939 (Date rec'd by registrar) (b) J. H. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 31, 1939, at 3:03 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-30-1939, to 5-31-1939, and that I last saw him alive on 5-31-1939.

Immediate cause of death	Duration
Coronary Thrombosis	15 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Wm. F. Williams M. D. or other
Address: Cumberland Md. Date signed 5/31/39

DR. W. F. WILLIAMS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (183)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

04561

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Potomac River - Maryland Side

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(d) Street No. 1015 Grape Alley. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Jackson Leo O'Baker Jr.

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1931

8. AGE: Years 7 | Months 11 | Days 18 | If less than one day ____hr. ____min.

9. Birthplace Cumberland (Town, county, and state)

10. Usual occupation School child

11. Industry or business

FATHER 12. Name Leo O'Baker

13. Birthplace Wellersburg Pa.

MOTHER 14. Maiden Name Bessie Knepper

15. Birthplace W. Va.

16 (a) Informant Leo O'Baker

(b) Address 1015 Grape Alley

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3 1939 (month) (day) (year)

(c) Cemetery or crematory Mt. Hermon Cem.

Location Cumberland

18 (a) Funeral director Jacob Hafer

(b) Address Cumberland Md.

19 (a) June 2 1939 (Date rec'd by registrar) (b) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 31 1939, at about 5 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-31 1939, to 5-31 1939, and that I last saw him alive on 5-31 1939.

Immediate cause of death	Duration
Accidental drowning,	5 min.
While swimming, with severe other injuries.	
Due to Caught in eddy	Over 1 hr.
At a deep place, in the Potomac River	
Due to	
There was no boat involved.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. V. Deming M.D. (Coroner) M. D. or other

Address 67 N. Center St Date signed 6/3/39

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (99)

CERTIFICATE OF DEATH

04562

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 306 Fayette St (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs. Lucretia Parker

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Robert Parker

6(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): July 13, ~~1882~~ 1881

8. AGE: Years: 57 Months: 9 Days: 28 If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Henry Hutson

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Frances Downey

15. Birthplace: West Virginia

16. Informant: Memorial Hospital

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14-39 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md.

18. Funeral director: U. L. Lemperenr.

Address: Cumberland, Md.

19. 5/13/39 (Date rec'd by registrar) 19 J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: May 11, 1939 2:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 1939 to May 11 1939 and that I last saw h[illegible] alive on May 11 1939

Immediate cause of death	DURATION
Thrombosis Right	
Due to Leg	
Due to	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D. M. D. or other

Address: 172 So Centre St Date signed:

Dr. Mathews

RECEIVED
JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 9

WITHIN CORPORATE LIMITS 04563

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County: Allegany

(b) City or town: Ellerslie Md. (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 105 Maple St

(d) Length of stay in hospital or inst. (yrs., mos., or days): —

(e) Length of stay in this community (yrs., mos., or days): 1da.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State: Pa. (b) County: Somerset

(c) City or town: Meyersdale (If outside city or town limits, write RURAL and give town)

(d) Street No. R. F. D # 2 (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** W^m J Rae

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Isabella Brimlow

6. (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.): Feb 13, 1872

8. AGE: Years	Months	Days	If less than one day
67	3	15	____hr. ____min.

9. Birthplace: Frostburg Md. (Town, county, and state)

10. Usual occupation: Salesman for Meyersdale

11. Industry or business: Cork - Linz (Memorials) Pa

FATHER

12. Name: John Rae

13. Birthplace: Scotland

MOTHER

14. Maiden Name: not known

15. Birthplace: not known

16 (a) Informant: C Las Brimlow

(b) Address: Borden Shaft. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29, 1939 (month) (day) (year)

(c) Cemetery or crematory: Union Cemetery

Location: Meyersdale Pa.

18 (a) Funeral director: Wm. Rowe Price

(b) Address: Meyersdale, Pennsylvania

19 (a) 5-26'39 (Date rec'd by registrar) (b) Mrs. A.R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death May 26 1939, at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-26 1939, to 5-26 1939, and that I last saw him ~~alive~~ dead on 5-26 1939.

Immediate cause of death	Duration
Coronary Thrombosis	(a)
Due to Arteriosclerosis	several yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature: H. L. Hemming M.D. Coroner (M. D. or other)

Address 67 N. Center St Cumberland, Md. Date signed 5-26-39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (126a) CP Reg. Dist. No. 9

CERTIFICATE OF DEATH

04564

VS. A15 (T) (I) (M) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution Miners Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in this community (yrs., mos., or days) 1 Week

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Texas (b) County
(c) City or town San Antonio (If outside city or town limits, write RURAL and give town)
(d) Street No. R. F. D. (If rural give location)
(e) If foreign born, how long in U. S. A.? years ✓

3 (a) **FULL NAME** Pauline Rahe

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6. (c) If alive, give age [redacted] years

7. Birth date of deceased (mo., day, yr.) Sept 28 1924

8. **AGE:** Years: 18 | Months: 7 | Days: 10 | If less than one day: hr. min.

9. Birthplace Texas (Town, county, and state)

10. Usual occupation Trapeze performer

11. Industry or business Carnival

FATHER
12. Name Harry [illegible] Rahe
13. Birthplace Texas

MOTHER
14. Maiden Name Ida Minnie
15. Birthplace Texas

16 (a) Informant Bernice Eaton
(b) Address San Antonio Texas

17 (a) Removable (Burial, cremation, or removal) (b) Date thereof May 9 (1939) (month) (day) (year)
(c) Cemetery or crematory
Location Texas

18 (a) Funeral director J. J. Kinsel
(b) Address Frostburg

19 (a) 5-9-'39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. **Date of death** May 8 1939, at 6 1/2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1939, to May 8 1939, and that I last saw HER alive on May 8 1939.

Immediate cause of death	Duration
Circulatory & respiratory Failure	
Due to: Brain Concussion	
Due to Fall from trapeze	
Other conditions Fracture of Both Legs	

(Include pregnancy within 3 months of death)

Major findings:
Of operations nil
Of autopsy nil

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence May 7, 1939
(c) Where did injury occur? Frostburg, Allegany Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public place (Specify type of place) While at work? Yes
(e) Means of injury Fall from Trapeze

23. **Signature** John Kilday, M. D. (M. D. or other)
Address 56 W. Main St. Frostburg, Md Date signed 5/9/39

RECEIVED
BUREAU V. S.

RECEIVED
MAY 27 1960
BUREAU V. S.

Outside of City Limits

CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (97) Reg. Dist. No. 4

CERTIFICATE OF DEATH

04565

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland R. D.
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Hinkle Rd.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 87yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Cumberland R. D.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hinkle Road
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME: Columbus Rice

3 (b) If veteran, name war:

3 (c) Social Security No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife: Emma Rice

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1851

8. AGE: Years 87 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Thomas V. Rice
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Rebecca Budy
15. Birthplace: Maryland

16 (a) Informant: Harry G. Rice
(b) Address: Cumberland, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25, 1939 (month) (day) (year)
(c) Cemetery or crematory Mt. Pleasant Cem.
Location Baltimore Pike

18 (a) Funeral director J. C. Wolford
(b) Address Cumberland, Md.

19 (a) 5/25/39 (Date rec'd by registrar) (b) J. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 23, 1939, at 7:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1939 to May 23 1939 and that I last saw him alive on May 23 1939.

Immediate cause of death	Duration
(a) Uremia	3 days
(b)	
Due to (c)	
Due to (d)	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. P. Hodges Jr. M. D. or other
Address Cumberland, Md. Date signed 5/27/39

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 8 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

STATE OF MARYLAND—CERTIFICATE OF DEATH

04566

1. PLACE OF DEATH (97)

County Allegany Registration Dist. No. 4

Village or City Cumberland No. Sylvan Retreat St. 3-3 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Henry Riehl If U. S. Veteran, specify WAR ____

(a) Residence: No. 496 Williams St., ____ Ward. ____

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ____

6. DATE OF BIRTH (month, day, and year): 1870

7. AGE: Years 69 | Months | Days | If LESS than 1 day, ____ hrs. or ____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Tailor

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Retired 5 yrs.

10. Date deceased last worked at this occupation (month and year) ____

11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) (State or country): Cumberland Md.

FATHER

13. NAME: John Riehl

14. BIRTHPLACE (city or town) (State or country): Germany.

MOTHER

15. MAIDEN NAME: Mathilda Shellhorn.

16. BIRTHPLACE (city or town) (State or country): Germany.

17. INFORMANT (Address): Mrs Elizabeth Damm 496 Williams St.

18. BURIAL, CREMATION, OR REMOVAL

Place: Trinity Lutheran Cem. Date: May 29, 1939

19. UNDERTAKER (Address): Louis Stein Inc. Cumberland

20. FILED: May 29, 1939 J. P. Franklin, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH 5 (Month) - 26 (Day) - 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Feb. 1939 to 5.26. 1939

I last saw him alive on 5.24. 1939, death is said to have occurred on the date stated above, at 3 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	?

Other Contributory Causes of Importance:

Name of operation: None Date of ____

What test confirmed diagnosis? Phy Exam Was there an autopsy? No.

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of Injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of Injury ____

24. Was disease or injury in any way related to occupation of deceased? No.

If so, specify ____

(Signed) H. C. Williams M. D.

(Address) Cumberland, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

RECEIVED JUN 8 1939 BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (89-a) CB Reg. Dist. No. 4

CERTIFICATE OF DEATH

04567

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Allegany Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State W. Va (b) County Mineral
(c) City or town Fort Ashby.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Richard Franklin Riley

3 (b) If veteran, name war

3 (c) Social Security No. 217-10-4938

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Eva Pyles

6. (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Sept 10, 1912

8. AGE: Years 26 Months 7 Days 21 If less than one day hr. min.

9. Birthplace Fort Ashby
(Town, county, and state)

10. Usual occupation Spinner

11. Industry or business Celenese Corp.

FATHER
12. Name Albert Riley
13. Birthplace Short Gap W. Va.

MOTHER
14. Maiden Name Levina Chaney
15. Birthplace Fort Ashby W. Va.

16 (a) Informant Mrs Ethel Pyles
(b) Address Fort Ashby W. Va

17 (a) ~~Fort H~~ Burial (Burial, cremation, or removal) (b) Date thereof May 3, 1939 (month) (day) (year)
(c) Cemetery or crematory Fort Hill Cemetery
Location Fort Ashby W. Va

18 (a) Funeral director Jacob Hafer
(b) Address Cumberland, Md.

19 (a) 5/3/39 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death 5/1/39 19, at 12 25 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/21/39 19, to 5/1/39 19, and that I last saw him alive on 4/30/39 19.

Immediate cause of death Streptococcic Meningitis

Due to Streptococcus

Due to ~~M~~

Other conditions Middle Ear infec.
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard J. Williams, M.D.
M. D. or other

Address 34 Va. Ave., Cumberland, Md Date signed 5/1/39

Dr Rich Dr Wms.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

04568

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 day

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. #128½ Polk Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MRS. GRACE SHARER

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	married

8 (b) Name of husband or wife William Sharer

6(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) August 1st 1890

8. AGE:

Years	Months	Days	If less than one day
48	9	6	hrs. min.

9. Birthplace Clearville Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name — Grubb
13. Birthplace Pa.

MOTHER
14. Maiden name Salina Chamberlain
15. Birthplace Pa.

16. Informant Wm Sharer
Address 128½ Polk St Cumb'd Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9 39 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. May 9, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7, 1939, at 8.27 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6, 1939, to May 7, 1939, and that I last saw her alive on May 6, 1939

Immediate cause of death Coronary Thrombosis Second attack

DURATION 36 hours

Due to

Due to

Other conditions Ovarian Cyst Twisted pedicle, Extreme pain.
(Include pregnancy within 3 months of death)

Major findings:
Of operations Cyst drained for relief of pain.
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A H Hawkins M. D. or other

Address Cumberland Date signed 5-9-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1969
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (46-B)

Reg. Dist. No. 4

04569

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 218 Bedford St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 1 yr 6 mo

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 218 Bedford St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Catherine J Sharp.

3 (b) If veteran, name war —
3 (c) Social Security No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Harry J Sharp.
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2 1861

8. AGE: Years 77 Months 6 Days 13 If less than one day hr. min.

9. Birthplace Berrysburg Pa.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Moses Fernsler
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Hauer
15. Birthplace Pa.

16 (a) Informant Rev H Hall Sharp.
(b) Address Cumberland.

17 (a) Removal & Burial (Burial, cremation, or removal) (b) Date thereof May 17 '39 (month) (day) (year)
(c) Cemetery or crematory Zion Lutheran Cem.
Location Enola Pa.

18 (a) Funeral director Louis Stein Inc.
(b) Address 117 Frederick St.

19 (a) 5/16/39 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 15 1939, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch. 8 1939, to May 15 1939, and that I last saw him alive on May 14 1939.

Immediate cause of death	Duration
Carcinoma of Stomach	1938
Due to Stoxxation & Exhaustion	2 mo
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. H. Kaan M. D. or other
Address Cumberland Md Date signed

VS. A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH
Bureau of Vital Statistics, Baltimore (97)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

04570

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland Md
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Sylvan Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs
(e) Length of stay in this community (yrs., mos., or days) 7 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Borden Mtn Md
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Henry Shuckhart

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Ellen Porter

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1859

8. AGE: Years 80 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Franklin Md
(Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal Mine

FATHER
12. Name Wm Shuckhart
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Shaffer
15. Birthplace Germany

16 (a) Informant Mrs A C Hopkins
(b) Address Frostburg Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22, 1939 (month) (day) (year)
(c) Cemetery or crematory Allegany
Location Frostburg Md

18 (a) Funeral director Jacob Hafer
(b) Address Frostburg

19 (a) 5/22/39 (Date rec'd by registrar) (b) J. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death 5. 20. 1939, at 5 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1934, to 5. 20. 1939
and that I last saw him alive on 5. 15. 1939.

Immediate cause of death	Duration
Arterio sclerosis	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jno F. Williams M. D. or other
Address Cumberland Date signed 5.20.39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

04571

1. PLACE OF DEATH
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 221 Independence St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 60 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 Independence (If rural give location)
(e) If foreign born, how long in U. S. A.? 65 years

3 (a) FULL NAME Bertha Slezak.

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Joseph Slezak

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1854

8. AGE: Years 85 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Austria (Town, county, and state)

10. Usual occupation Housework

11. Industry or business at Home.

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Mrs Bessie McCleary
(b) Address 221 Independence St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29 39 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Cumberland

18 (a) Funeral director Louis Stein Sons
(b) Address Cumberland

19 (a) May 29 1939 (Date rec'd by registrar) (b) J. L. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 26 1939, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1939, to May 26 1939, and that I last saw him alive on May 15 1939.

Immediate cause of death	Duration
Myocarditis Chr.	1 yr.
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter R. Brantz M.D. (M. D. or other)
Address Cumberland Md Date signed May 26/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 10

CERTIFICATE OF DEATH

04572

VS. A15 (T)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) County: Allegany

(b) City or town: Mt Savage (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Mt Savage Road

(d) Length of stay in hospital or inst. (yrs., mos., or days):

(e) Length of stay in this community (yrs., mos., or days):

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Mt. Savage (If outside city or town limits, write RURAL and give town)

(d) Street No. Mt Savage Rd (If rural give location)

(e) If foreign born, how long in U. S. A.? 2 years

3 (a) **FULL NAME** Reginald C. Smith

3 (b) If veteran, name war:

3 (c) Social Security No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife:

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15-1880

8. AGE: Years	Months	Days	If less than one day
58	10	23	hr. min.

9. Birthplace Renfrew + Canada (Town, county, and state)

10. Usual occupation retired

11. Industry or business R. Way Clerk

FATHER
12. Name
13. Birthplace Ont. Canada

MOTHER
14. Maiden Name Williams
15. Birthplace U.S.A.

16 (a) Informant Mrs Lambie

(b) Address Mt. Savage, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 9 39 (month) (day) (year)

(c) Cemetery or crematory Cemetary

Location Renfrew Canada

18 (a) Funeral director J. J. Dungan

(b) Address Frostburg, Md

19 (a) 5-8-39 (Date rec'd by registrar) (b) H. J. Bostetter M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 8 1939, at 4:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1939; to May 8 1939, and that I last saw him alive on May 8 1939.

Immediate cause of death	Duration
(a) Pneumonia,	2 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. J. Bostetter M.D. (M. D. or other)

Address Mt Savage Md Date signed 5-8-39

RECEIVED
MAY 30 1989
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (165) CNB Reg. Dist. No. 9

CERTIFICATE OF DEATH

04573

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Zihlman, Md.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 5 mo.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State New York ~~City~~ (b) County

(c) City or town New York city
(If outside city or town limits, write RURAL and give town)

(d) Street No. 248 Centre Ave., New Rochelle
(If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Minnie M. Stevener

3 (b) If veteran, name war —

3 (c) Social Security No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1873

8. AGE: Years 65 Months 4 Days 14 If less than one day hr. min.

9. Birthplace Zihlman, Allegany Co., Md
(Town, county, and state)

10. Usual occupation Governess

11. Industry or business ?

FATHER
12. Name Job Stevens
13. Birthplace England

MOTHER
14. Maiden Name Agnes Stephens
15. Birthplace England

16 (a) Informant Mrs. Eliza Miller
(b) Address Zihlman Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12, 1939 (month) (day) (year)

(c) Cemetery or crematory Allegany Cem.

Location Frostburg, Md.

18 (a) Funeral director Jacob Hafer

(b) Address Frostburg, Md.

19 (a) 5-10-'39 (Date rec'd by registrar) (b) Ms. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death May 9 1939, at about 5 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1939, to May 9 1939, and that I last saw ~~him~~ her alive on May 9 1939.

Immediate cause of death Strangulation

Due to Suicide

Due to Nervousness

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration
at once
at once
about 6 mo.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide suicide

(b) Date of occurrence May 9. 1939

(c) Where did injury occur? Zihlman (City or town) Allegany (County) Md (State)

(d) Did injury occur about home, on farm, industrial place, in public place? On Geo Miller farm (Specify type of place) While at work?

(e) Means of injury

23. Signature H. V. Deming M.D. M.D. or other

Address 67 N. Center St. Cumberland, Md. Date signed Coroner

VS. A15 (T) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (82-D)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

01574

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 537 N. Mechanic St.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 8 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(d) Street No. 537 N. Mechanic St. (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Wm. Ralph Thomas

3 (b) If veteran, name war

3 (c) Social Security No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Nancy Bell Workman

6. (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) June 7 1876

8. AGE: Years	Months	Days	If less than one day
62	11	1	____ hr. ____ min.

9. Birthplace Frostburg Md. (Town, county, and state)

10. Usual occupation Store Keeper

11. Industry or business Grocery Store

FATHER 12. Name Wm. B. Thomas

FATHER 13. Birthplace Wales

MOTHER 14. Maiden Name Elizabeth A. Lewis

MOTHER 15. Birthplace Wales

16 (a) Informant Wm P. Thomas

16 (b) Address Eckhart Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12, 1939 (month) (day) (year)

17 (c) Cemetery or crematory Rose Hill Cemetery

Location Cumberland Md.

18 (a) Funeral director Jacob Hafer

18 (b) Address Cumberland Md.

19 (a) May 9, 1939 (Date rec'd by registrar) (b) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. Date of death 5-8-39 19___, at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19 19 39, to 5-8-39 19___ and that I last saw him alive on 5-7-39.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 wks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. Alfred Van Orsdel M. D. or other

Address Cumberland, Md. Date signed 5-8-39

Van Orsdel

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 6 1909
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

04575

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 57 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 19 Humbird St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George M Twigg

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret A Hoover
6(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Mar 18 1882

8. AGE: Years 57 | Months 2 | Days 13 | If less than one day ____ hrs. ____ min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Ass Inspector
11. Industry or business B & O R R.
FATHER 12. Name Israel Twigg
13. Birthplace Md.
MOTHER 14. Maiden name Nancy Hays
15. Birthplace Md.
16. Informant Mrs. Geo M. Twigg
Address Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2 '39 (month) (day) (year)
Cemetery or crematory Hillcrest Cem.
Location Cumberland
18. Funeral director Louis Stein Sons.
Address Cumberland
19. June 2 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1939, at 8:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31, 1939, to ____ 19____, and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Pronounced dead on arrival at Memorial Hosp.	
Due to Cardiac Death (?)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clay E. Durrett M. D. or other
Address Cumberland, Md Date signed May 31, 1939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (157-d) Reg. Dist. No. 2

CERTIFICATE OF DEATH

04576

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Flintstone
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED
(a) State Md (b) County Allegany
(c) City or town Flintstone Md
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Fred Vance

3 (b) If veteran, name war | 3 (c) Social Security No.

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1939

8. AGE: Years | Months | Days | If less than one day 18 hr. min.

9. Birthplace Allegany Co. Md.
(town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Omar Vance
13. Birthplace ~~Ohio~~ W. Va.

MOTHER 14. Maiden Name Garnet Walton
15. Birthplace Ohio

16 (a) Informant Omar Vance
(b) Address Flintstone Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29 (month) (day) (year)
(c) Cemetery or crematory Mt Hope
Location Bedford Co Pa

18 (a) Funeral director Ephraim Smith
(b) Address Artemas Pa

19 (a) May 28 (Date rec'd by registrar) (b) D. Bennett Registrar

MEDICAL CERTIFICATION

20. Date of death May 28 1939, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1939, to May 28 1939, and that I last saw him alive on May 27 1939.

Immediate cause of death	Duration
Congenital	
Malformation: no genital tract.	
Due to Cerebral hemisphere exposed. Cleft P.	
Upper lip fissured; no palate; six toes	
Due to on each foot.	
Other conditions Lack of nourishment.	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. P. Twigg M. D.
(M. D. or other)
Address Flintstone Date signed 5-28-39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 6 1923
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-E) Reg. Dist. No. 9

CERTIFICATE OF DEATH

04577

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cresaptown (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution County Rd.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Cresaptown (If outside city or town limits, write RURAL and give town)
(d) Street No. County Rd. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary Ellen Ware

3 (b) If veteran, name war -

3 (c) Social Security No. -

4. Sex Female

5. Color or race W.

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife 0

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6 1869

8. AGE: Years 69 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Reynoldsville Pa (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name John Ware
13. Birthplace Ireland

MOTHER
14. Maiden Name Mullen
15. Birthplace Ireland

16 (a) Informant Carl A. Ware
(b) Address Frostburg Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 (month) 29 (day) 39 (year)
(c) Cemetery or ~~crematory~~ Allegany
Location Frostburg Md

18 (a) Funeral director Dent
(b) Address Frostburg Md

19 (a) 5-29-39 (Date rec'd by registrar) (b) mo A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death May 26 1939, at 1 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-20-1939, to 5-26-1939, and that I last saw him alive on 5-26-1939.

Immediate cause of death	Duration
Chronic Cardiac Collapse	
Due to Chronic Myocarditis	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Ogburn M. D. or other
Address Frostburg Md. Date signed 5-27-39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 6 1939
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (1880) Reg. Dist. No. 6

CERTIFICATE OF DEATH

04578

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Westernport
WITHIN CORPORATE LIMITS (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 433 Vine
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 3 14

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Westernport (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 Vine St. (If rural give location)
(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** John Ralph Welsh

3 (b) If veteran, name war

3 (c) Social Security No. 216-07-3403

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rose Smith Welsh

6. (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) July 18, 1885

8. **AGE:** Years 55 | Months 7 | Days 15 | If less than one day _____ hr. _____ min.

9. Birthplace Barton, Md. (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business General Merchandise

FATHER
12. Name James A. Welsh
13. Birthplace Bloomington, Md.

MOTHER
14. Maiden Name Mary Brown
15. Birthplace Elk, Garden, W. Va.

16 (a) Informant Joseph W. Welsh
(b) Address Westernport, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6 1939 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Westernport

18 (a) Funeral director D. S. Boyle
(b) Address Barton Md.

19 (a) May 6, 1939 (Date rec'd by registrar) (b) G. Braynhaber M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 3 1939 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1939, to May 3 1939, and that I last saw him alive on May 3 19_____.

Immediate cause of death (Probably)	Duration
Acute Nephritis	2 wks.
Acute Alcoholism	1 wk.
Due to Broncho-Pneumonia	2 days
Due to	
Other conditions Fully Broken Rib in Bathroom (Include pregnancy within 3 months of death)	1 day

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. E. Berry, M.D. (M. D. or other)
Address Piedmont W. Va. Date signed 5/4/39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 3 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (94E) Reg. Dist. No. 1

CERTIFICATE OF DEATH

04579

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Rural - Little Orleans, Md
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 47 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Rural Little Orleans
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mark Jeremiah Whitfield

3 (b) If veteran, name war
3 (c) Social Security No.

4. Sex Male
5. Color or race white
6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Catherine Whitfield
6. (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1873

8. AGE: Years 65 Months 9 Days 5 If less than one day hr. min.

9. Birthplace Silver Mills, Bedford Co. Pa.
(Town, county, and state)

10. Usual occupation farmer

11. Industry or business farming

FATHER
12. Name Ephriam Whitfield
13. Birthplace Penna.

MOTHER
14. Maiden Name Nancy Welch
15. Birthplace Penna.

16 (a) Informant Olney Whitfield
(b) Address Little Orleans Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29 1939 (month) (day) (year)
(c) Cemetery or crematory
Location Piney Plains ME Cemetery

18 (a) Funeral director Ephriam Smith
(b) Address R. F. D. 1 Artemas, Penna.

19 (a) May 28 1939 (Date rec'd by registrar) (b) T. T. Mann (Per) M E Mann Dep. Local Registrar

MEDICAL CERTIFICATION

20. Date of death May 26 1939 at 10:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1938, to May 10 1939, and that I last saw him alive on May 10 1939.

Immediate cause of death Coronary occlusion — Duration

Due to

Due to Auricular Fibrillation

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations ✓
Of autopsy ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. H. Cutler MD
M. D. or other

Address 134 N. Potomac Hagerstown, Md Date signed 5-27-39

MARGIN RESERVED FOR BINDING

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VS. A15 (T) (M)

RECEIVED
JUN 6 1939
BUREAU V. S.